



2002 Minnesota Milestones, archived version

Note to users: The content below was featured on a website that is no longer live. All of the data and discussion, however, remains below. This document is organized by a summary of indicators in four sections — People, Community & Democracy, Economy, and Environment. Discussion and trend data for each indicator appears following the indicator list specific to each section.

PEOPLE SECTION

Our children will not live in poverty.

- 1 [Child poverty](#)
- 2 [Low-income school children](#)

Families will provide a stable, supportive environment for their children.

- 3 [Satisfaction with child care](#)
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All children will be healthy and start school ready to learn.

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Minnesotans will excel in basic and challenging academic skills and knowledge.

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INDICATOR 1 : CHILD POVERTY

Goal: *Our children will not live in poverty.* Poverty can do both immediate and lasting harm to children. Children who grow up in poverty are more likely to lack adequate food and clothing, live in poor housing, become victims of crime and violence, lack basic health care and be less successful in school.

Rationale: Household poverty is the most direct indicator of the economic status of children.

About this indicator: This indicator reports the percentage of children under age 18 living in households below the federal poverty line. The percentage of children under 18 living in households below the federal poverty line rose from 10.2 percent in 1980 to 12.4 percent in 1989 but fell to 9.2 percent in 1999. The poverty line is a federal estimate of the pretax annual income needed to meet basic living costs, adjusted for family size. In 2000, the poverty level for a family of four was \$17,603. Historically, poverty rates in Minnesota are highest among American Indian children, closely followed by African American families. Child poverty has also been considerably higher in Hispanic and Asian families than in non-Hispanic White families.

For comparison: Nationally, in 1999, 16.1 percent of children under 18 lived in households below the federal poverty line. This is significantly above the Minnesota rate of 9.2 percent.

Things to think about: In 1999, the percentage of children living in poverty varied from county to county; Beltrami County and Mahnomon County were the highest at 21.7 percent and 21.3 percent respectively. Scott, Sherburne, Washington and Dakota Counties had the smallest rates, ranging from 3.4 percent to 3.9 percent. In the state's two most populous counties rates were higher in Ramsey County, at 15.7 percent, than in Hennepin County, at 10.45 percent. In the two counties overall, this represented 47,448 children.

Technical notes: The U.S. Department of Commerce adjusts the poverty level annually to reflect changes in the Consumer Price Index. Reliable state-level data is available only every 10 years from the U.S. Census. The Census Bureau produces annual estimates of poverty rates between census years, but the estimates are based on survey samples too small to provide dependable data for Minnesota. For reference, the 1998 estimate was that 12.6 percent of children in Minnesota live below the poverty line.

Sources:

- U.S. Bureau of the Census, Decennial Census, 1980, 1990 and 2000, www.census.gov.

INDICATOR 2 : LOW-INCOME SCHOOL CHILDREN

Goal: *Our children will not live in poverty.* Poverty can do both immediate and lasting harm to children. Children who grow up in poverty are more likely to lack adequate food and clothing, live in poor housing, become victims of crime and violence, lack basic health care and be less successful in school.

Rationale: Eligibility for free or reduced-price school meals is an important measure of child poverty trends, because it is updated every year.

About this indicator: The proportion of public school children from low-income families approved for free or reduced-price meals rose from 20.8 percent in 1989-90 to 26.3 percent in 1998-99. After stabilizing between 25 and 26 percent between 1996 and 2000, it fell in 2001, but rose to 26.6 percent in 2002.

Students are eligible for free lunch when family income is below 130 percent of the federal poverty level. They qualify for reduced-price lunch and breakfast when family income is between 130 percent and 185 percent of the poverty level. In 2000-01, 18.2 percent of children qualified for free lunch and 7.5 percent qualified for reduced-price meals.

Not every eligible child participates. It is believed that a smaller proportion of eligible students sign up in the reduced-price category and also that secondary students are less likely to sign up. However, recent research from the U.S. Department of Agriculture indicates discrepancies in reported income, leading to the enrollment of ineligible children.

For comparison: Federal data is collected differently making comparison impossible.

Things to think about: The trend varies widely by school district. Low-income students are more highly concentrated in the Twin Cities area. Both St. Paul and Minneapolis school districts saw large increases in student poverty during the 1990s, an increase of 23 percentage points in St. Paul and 20 percentage points in Minneapolis, while increases in suburban areas were minimal.

Technical notes: The percentages shown are for all school children in kindergarten through twelfth grade enrolled on October 1 of each school year, who are eligible and sign up for the program. Poverty levels are adjusted each year and vary with the size of the family.

Sources:

- Minnesota Department of Children, Families & Learning, *K-12 Economic Indicator Report*, <http://cfl.state.mn.us>
 - U.S. Department of Education, National Center for Education Statistics, www.nces.ed.gov
 - Memorandum from Mathematica Policy Research to U.S.D.A., February 16, 2001
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INDICATOR 3 : SATISFACTION WITH CHILD CARE

Goal: *Families will provide a stable, supportive environment for their children.* Supportive and nurturing relationships promote children's emotional security, social development and academic achievement.

Rationale: Research indicates that ensuring preschool children have access to high quality, stable, educational child care is an important factor in achieving this goal.

About this indicator: Parents' ratings of child care quality remain consistently high. This includes both formal child care settings and informal care from relatives, friends and neighbors. Since annual surveys began in 1997, the satisfaction level has been steady at 96 or 97 percent. In 2000 it was 98

percent. About two-thirds (68%) of Minnesota children, age 14 and younger, are in the care of someone other than their parents at least once a week.

For comparison: No comparable survey results are available, nationwide or for other states.

Things to think about: Nearly half (45 percent) of Minnesota children age five and under are in the care of someone other than their parents for 20 hours or more per week. Two-thirds of these receive full-time care (35 or more hours a week).

Relatives are the most common caregivers for Minnesota children (29 percent) followed closely by family child care homes (23 percent) and child care centers (20 percent). Other care arrangements include informal care by a non-relative (11 percent), supervised activities (11 percent) and self-care (7 percent).

Parents using different kinds of child care have different expectations. During 1999-2000, nearly 2,500 Minnesota families participated in a study of child care use and preferences conducted by the Wilder Research Center for the Minnesota Department of Children, Families & Learning. The study found that parents relying on relatives and other informal arrangements tend to highly rate the individual attention, flexibility and stability of that type of care. Those using formal arrangements rate more highly creative activities, the caregivers' knowledge of children's needs, activities that are "just right" for their child and not watching too much TV.

Technical notes: This indicator is based on a random statewide survey of 800 families. Experts believe that parents might be reluctant to admit concerns about their children's child care in a telephone survey. For these reasons, conclusions about satisfaction levels should be treated with caution. The question asked since 1997 is, "Thinking about your children under 12, how satisfied are you with the quality of care they receive when you are not with them: very satisfied, satisfied, dissatisfied or very dissatisfied?" This is very slightly different from the question asked previously.

Sources:

- Minnesota Department of Children, Families & Learning, <http://cfl.state.mn.us>.
 - University of Minnesota, Minnesota Center for Survey Research, Minnesota State Survey.
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INDICATOR 4 : SCHOOL TRANSFERS

Goal: *Families will provide a stable, supportive environment for their children.* Supportive and nurturing relationships promote children's emotional security, social development and academic achievement.

Rationale: Studies of student mobility show that students who frequently change schools experience less success at school and have lower graduation rates.

About this indicator: Although no clear trend is evident, school transfers tended to be somewhat higher in the late 1990s than earlier in the decade. The rate has fluctuated between 12.8 and 14.8 percent. Frequent moves during childhood can be associated with delinquency, depression, teen pregnancy, or dropping out of school. While children sometimes change schools for positive reasons, high or increasing numbers of transfers show instability that can cause problems for both the transferring students and the schools.

Student mobility varies greatly from district to district. It is high in communities with a large number of migrant workers, those on or near Indian reservations and in fast-growing suburbs and regional centers. School transfers also remain high in Minneapolis and St. Paul, at 35.4 percent and 29.2 percent, respectively.

Things to think about: Some students change schools voluntarily for personal reasons, such as a failure to make friends. Others transfer because of academics to take advantage of specific programs. Many transfers, however, result not from deliberate choice but from instability in the family's or student's situation; these may be linked to the lack of safe, decent and affordable housing in certain areas.

Another issue is the effect student mobility has on schools. The data does not show how high student mobility may affect a school's test scores.

Technical notes: The data reflects children in kindergarten through grade 12 who change schools both within and between school districts. Due to changing enrollment patterns, school mobility data is now tracked differently than in the 1990s. Cooperative and intermediate districts have been excluded from the analysis. Data from 1993 forward was recalculated in March 2000 to more accurately reflect student transfers. The transfer rate now includes only transfers occurring after Labor Day. This reduced the number of transfers by two to three percent. Also, school mobility data does not include students who change schools between school years.

Sources:

- Minnesota Department of Children, Families & Learning, <http://cfl.state.mn.us>
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INDICATOR 5 : CHILD ABUSE AND NEGLECT

Goal: *Families will provide a stable, supportive environment for their children.* Supportive and nurturing relationships promote children's emotional security, social development and academic achievement.

Rationale: The risks of child abuse and neglect include physical injury, emotional illness, poor school performance and future criminal behavior.

About this indicator: The rate of child abuse and neglect has changed only slightly during the last decade. This includes cases of child abuse and neglect as a proportion of the under-18 population. The statistics are based on reports of neglect or abuse that are determined by the local welfare agency to be maltreatment. The rate has fluctuated between 8.2 and 9.3 per 1,000 since 1991, but increased 9.5 percent between 1998 and 2000. The rate of 9.2 abused or neglected children per 1,000 in year 2000 includes individual children for whom abuse was determined more than once. Looking at unique victims of determined maltreatment, the rate was 8.7 per 1,000 children.

In 2000, maltreatment was determined in just under half of the reports alleging abuse. The majority of determined cases were for neglect, followed in frequency by physical abuse, sexual abuse and mental injury.

Children age 10 and under represented the majority of victims of neglect. Over three-quarters of sexual abuse victims were girls. The rate of determined cases of abuse and neglect was more than

seven times greater for Black/African American children and eight times greater for American Indian children than for non-Hispanic White children, though the gap is smaller than in 1999. The majority of abusers were the child's birth parents. Neglected children were more likely to live in a family experiencing multiple family issues including substance abuse.

Eighteen children are known to have died from maltreatment in 2000, a reduction from 28 in 1999. Of these, 13 children died from physical abuse and five from neglect. In 1998, only three deaths from maltreatment were recorded. According to the Minnesota Department of Human Services, improvements in reporting procedures may account for some or all of the difference between 1998 and 1999.

For comparison: The incidence of child abuse and neglect is difficult to compare among states due to varying definitions and reporting practices.

Things to think about: In 2000, most of the 17,408 alleged maltreatment reports received a traditional child-protection response, requiring a judgment on whether a determination should be made. Over 900 cases in 20 counties were addressed through Alternative Response, a strengths-based community approach to addressing child maltreatment. With this new approach, no official determination is made, but a family assessment ascertains the family needs and strengths, the safety of the child and the risk of maltreatment. Intensive support services are offered to families at higher risk. Under this approach, fewer determinations may be recorded, but more families may receive help.

Technical notes: Comparisons of abuse and neglect rates throughout the decade should be treated with caution. Changes in case management, such as the increased emphasis on family support rather than determination, may reduce the number of determined cases recorded in the future. [Lincoln, Lyon and Murray counties merged their child protection systems in 1999. Faribault and Martin counties merged their systems in the same year.] County data is based on three year averages.

Sources:

- Minnesota Department of Human Services, Children's Research, Planning and Evaluation Division and the Family and Children's Services Division, *Child Maltreatment: A Minnesota Report*, www.dhs.state.mn.us

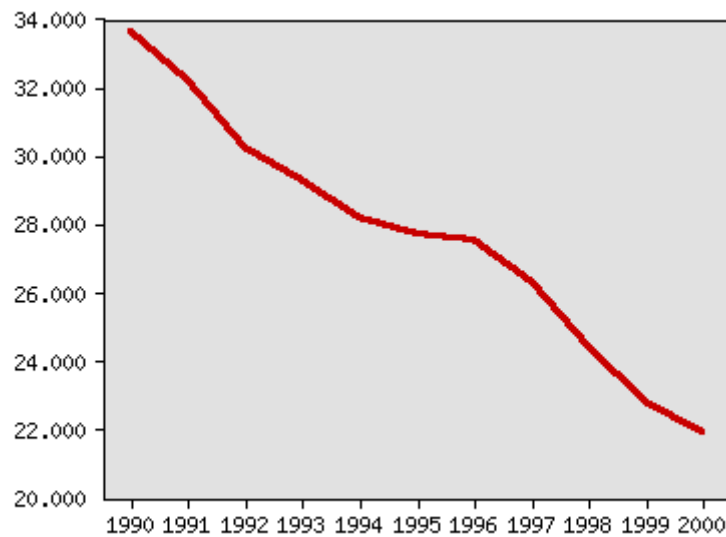
INDICATOR 6 : TEEN PREGNANCY

Goal: *Families will provide a stable, supportive environment for their children.* Supportive and nurturing relationships promote children's emotional security, social development and academic achievement.

Rationale: Teenage mothers, many of whom are single, face difficulties in providing a stable, supportive environment for their children.

Teen pregnancy rate per 1,000 girls ages 15 to 17, total

Year	
1990	33.6
1991	32.2
1992	30.2
1993	29.3
1994	28.2
1995	27.7
1996	27.5
1997	26.3
1998	24.4
1999	22.8
2000	21.9

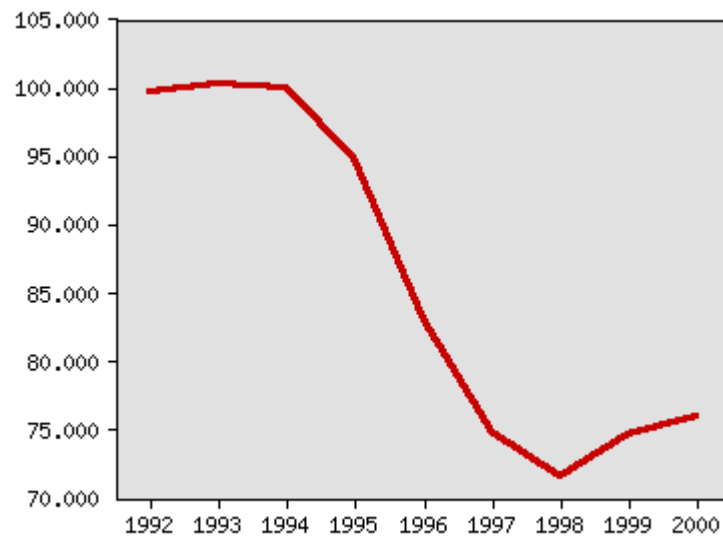


[Local data](#)

Data source: Minnesota Department of Health

Teen pregnancy rate per 1,000 girls ages 15 to 17, American Indian

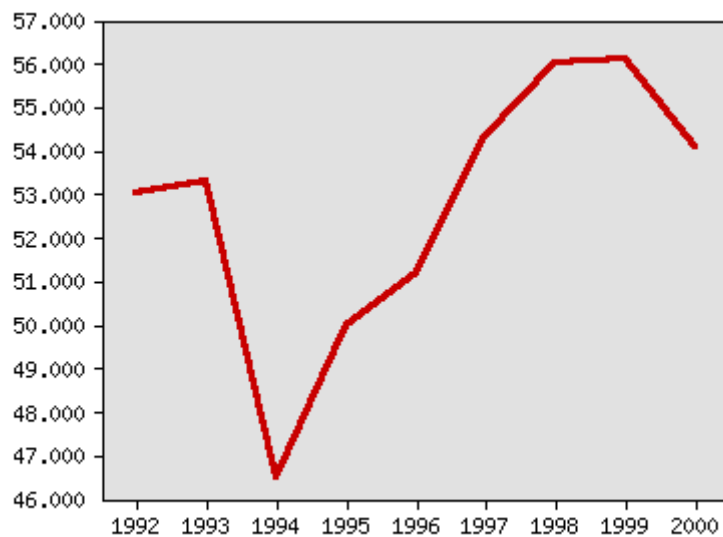
Year	
1992	99.6
1993	100.2
1994	99.9
1995	94.8
1996	83.0
1997	74.7
1998	71.6
1999	74.6
2000	75.9



Data source: Minnesota Department of Health

Teen pregnancy rate per 1,000 girls ages 15 to 17, Asian or Pacific Islander

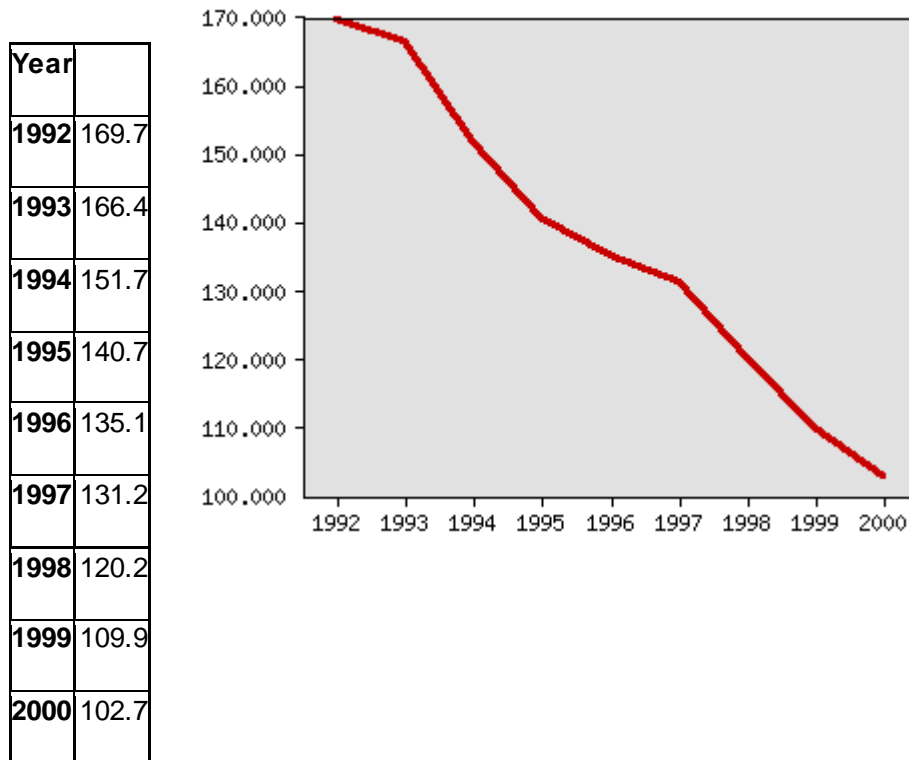
Year	
1992	53.0
1993	53.3
1994	46.5
1995	50.0
1996	51.2
1997	54.3
1998	56.0
1999	56.1



2000	54.1
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Data source: Minnesota Department of Health

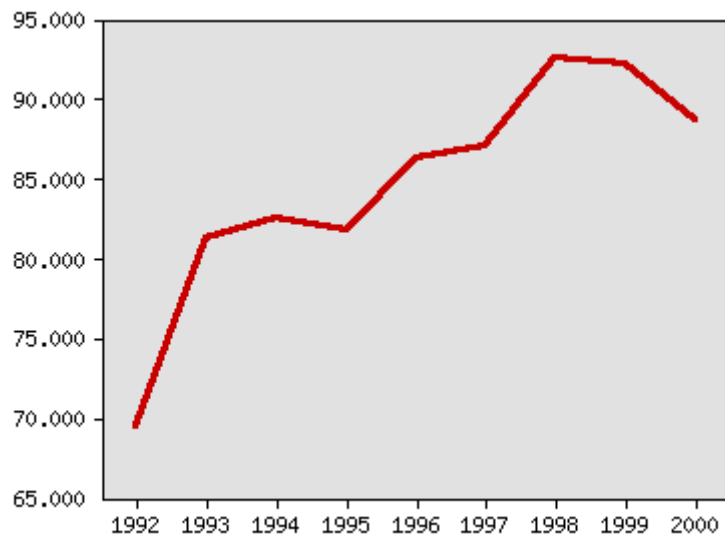
Teen pregnancy rate per 1,000 girls ages 15 to 17, Black/ African American



Data source: Minnesota Department of Health

Teen pregnancy rate per 1,000 girls ages 15 to 17, Hispanic

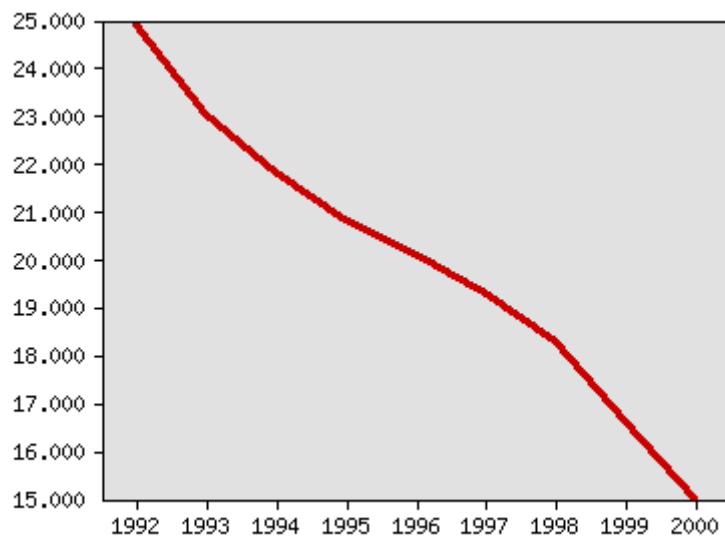
Year	
1992	69.5
1993	81.2
1994	82.5
1995	81.8
1996	86.3
1997	87.0
1998	92.5
1999	92.2
2000	88.6



Data source: Minnesota Department of Health

Teen pregnancy rate per 1,000 girls ages 15 to 17, White

Year	
1992	24.9
1993	23.0
1994	21.8
1995	20.8
1996	20.1
1997	19.3
1998	18.3
1999	16.6



2000	15.0
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Data source: Minnesota Department of Health

About this indicator: Minnesota's teen pregnancy rate declined steadily in the 1990s, from 33.6 per 1,000 in 1990 to 21.9 per 1,000 in 2000. The number of teen pregnancies for girls age 15-17 is calculated by combining the reported number of births, abortions and fetal deaths to mothers in this age group. Children born to teenage mothers are at higher risk for poor neonatal care, low birth weight and infant mortality. Teenage mothers can find it difficult to support a child. Only about half complete high school, limiting future job prospects. There is a high rate of welfare participation among the group.

Rates of teenage pregnancy vary greatly by race and ethnicity. In 2000, the rate per 1,000 girls age 15 to 17 ranged from 102.7 for African Americans to 15.0 for Whites. For Hispanics the rate was 88.6, for American Indians 75.9 and for Asian/Pacific Islanders 59.2. Since 1992 the rate of teen pregnancies in Minnesota has decreased in the White, American Indian and Black/African American populations, but increased among Asian/Pacific Islander and Hispanic teens. It has dropped most dramatically in the Black/African American population, from 169.71 in 1992 to 102.7 in 2000.

The Minnesota Department of Health had a goal of reducing the overall state rate to 26.9 by 2004. This has been met and surpassed by 1997.

For comparison: Teenage pregnancy rates in Minnesota are significantly below the national rate. In 1997, the U.S. pregnancy rate for this age group was 63.7 compared with 26.3 in Minnesota. However, the decline in Minnesota mirrors a national trend. The national rate is the lowest since consistent recording began in 1976.

Things to think about: Several factors likely contribute to the falling teenage pregnancy rates. According to several national surveys, teenage sexual activity has declined, possibly reflecting public efforts to focus teenagers' attention on pregnancy prevention through abstinence. Also important is increased use of contraceptives. Experts also believe that better economic prospects tend to give teenagers a reason to value education more highly and postpone early pregnancy and parenthood.

Technical notes: Data by race and ethnicity is based on a three-year average. County information is provided in three-year averages.

Sources:

- Minnesota Department of Health, Center for Health Statistics, www.health.state.mn.us
- Minnesota Department of Health, *Healthy Minnesotans: Minnesota Public Health Improvement Goals 2004*, June 1998
- U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, *Trends in Pregnancy Rates for the United States, 1976-97*, www.cdc.gov/nchs

INDICATOR 7 : RUNAWAYS

Goal: *Families will provide a stable, supportive environment for their children.* Supportive and nurturing relationships promote children's emotional security, social development and academic achievement.

Rationale: Many children or young people run away from home because they lack a stable, supportive home environment. Some are victims of abuse.

About this indicator: After a marked increase between 1990 and 1994, the runaway rate per 1,000 children decreased from 1994 to 1998, rising again in 1999 and 2000. The primary purpose of the data, which is collected as a provision of the Minnesota Missing Children's Act of 1984, is to assist in locating those children reported missing in the shortest possible time, thus ensuring their safe return.

For comparison: The Federal Bureau of Investigation collects national data on runaways in a different way, making comparison impossible.

Things to think about: Other categories of children missing from home are not included in these figures. They may have wandered away, be missing in suspicious circumstances or be the suspected victim of parental kidnapping. Over three quarters of runaways are located, with an almost equal number returning voluntarily and being located by the authorities.

Technical notes: The data is collected at the end of each month by law enforcement agencies and aggregated yearly. Data in *Minnesota Milestones 1998* was based on the number of runaways reported throughout the year. Since 1997, the Minnesota Department of Public Safety has reported only the number of cases remaining open at year's end. For consistency, Milestones data from 1990 to 1996 has been revised to include only cases remaining open at the end of the year. Including all cases reported during the year meant that some youth were counted multiple times. However, including only cases remaining open at the year's end understates the total number of runaways because many cases are closed before the data is collected.

Sources:

- Minnesota Department of Public Safety, Bureau of Criminal Apprehension, *Minnesota Missing Children Report*, www.dps.state.mn.us

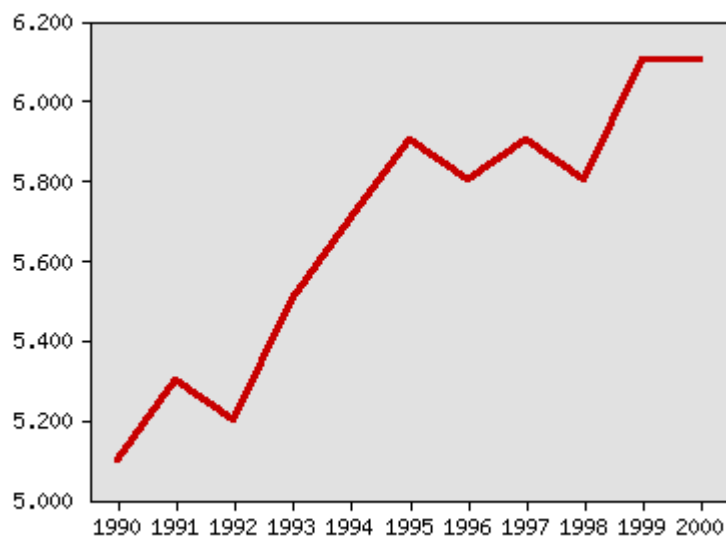
INDICATOR 8 : LOW BIRTH WEIGHT

Goal: *All children will be healthy and start school ready to learn.* The early childhood years – birth to age five – are a critical period of growth and development. Learning begins with a healthy, nurturing start in life. This goal reflects the growing scientific understanding that a healthy pregnancy and early nurturing contribute to a child's brain development and later success in school.

Rationale: Low birth weight is often associated with health and development problems.

Low birth weight babies, total (percent)

Year	
1990	5.1%
1991	5.3%
1992	5.2%
1993	5.5%
1994	5.7%
1995	5.9%
1996	5.8%
1997	5.9%
1998	5.8%
1999	6.1%
2000	6.1%

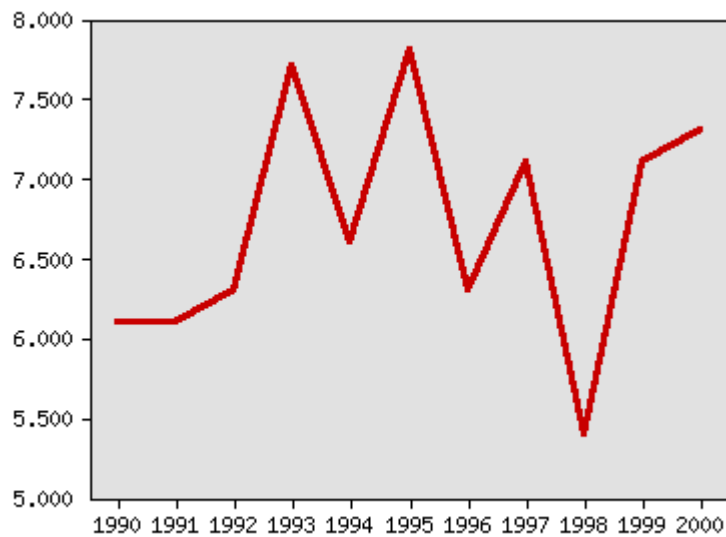


[Local data](#)

Data source: Minnesota Department of Health

Low birth weight babies, American Indian (percent)

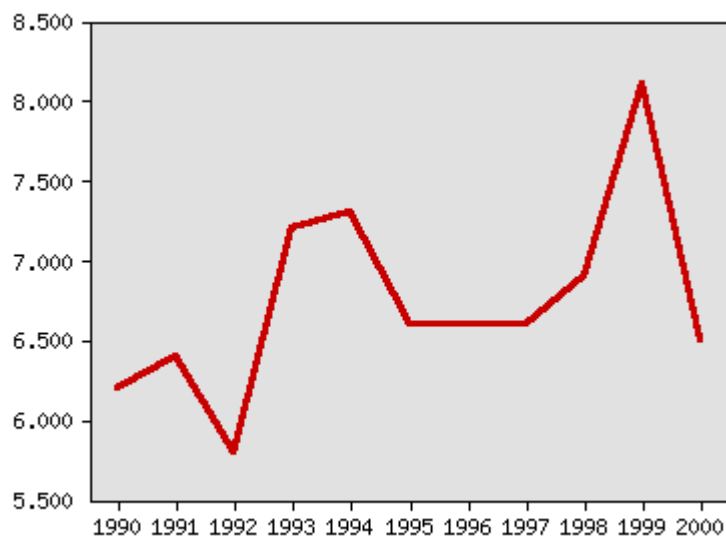
Year	
1990	6.1%
1991	6.1%
1992	6.3%
1993	7.7%
1994	6.6%
1995	7.8%
1996	6.3%
1997	7.1%
1998	5.4%
1999	7.1%
2000	7.3%



Data source: Minnesota Department of Health

Low birth weight babies, Asian or Pacific Islander (percent)

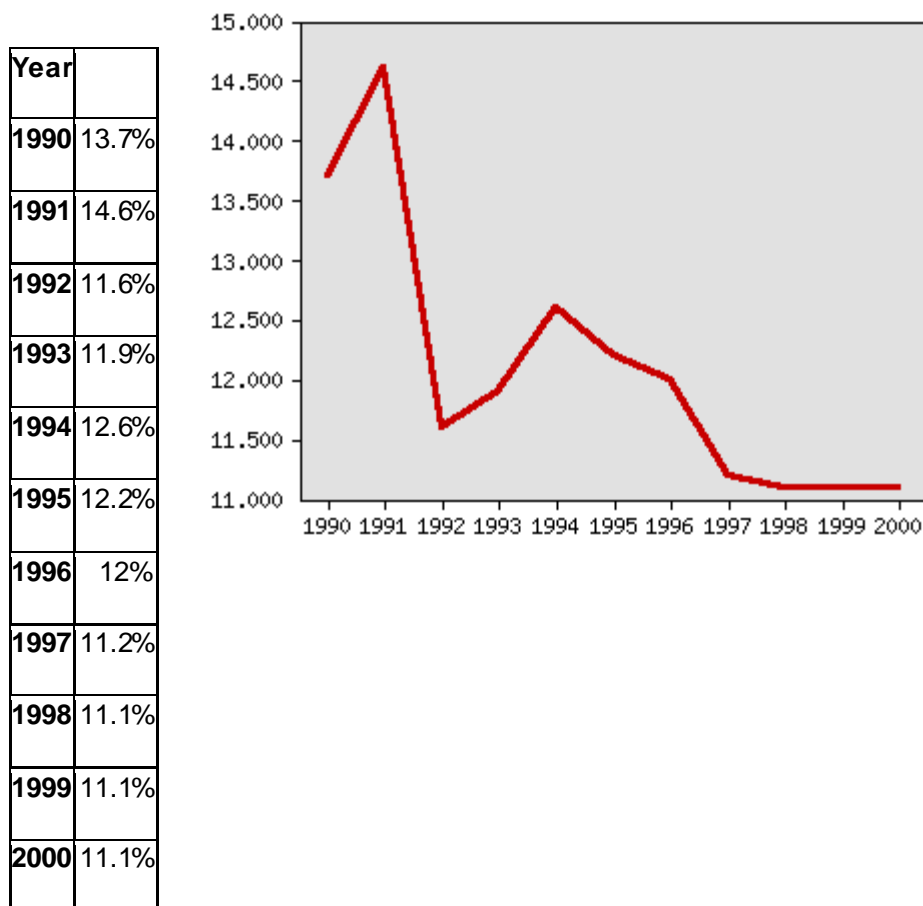
Year	
1990	6.2%
1991	6.4%
1992	5.8%
1993	7.2%
1994	7.3%
1995	6.6%



1996	6.6%
1997	6.6%
1998	6.9%
1999	8.1%
2000	6.5%

Data source: Minnesota Department of Health

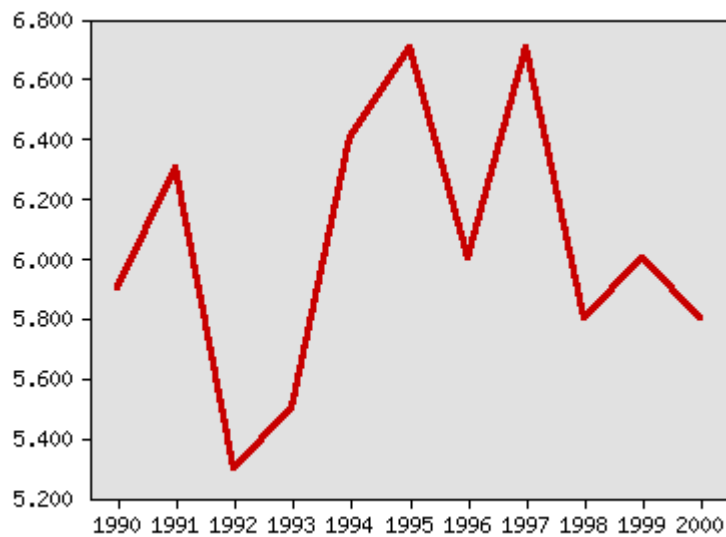
Low birth weight babies, Black/ African American (percent)



Data source: Minnesota Department of Health

Low birth weight babies, Hispanic (percent)

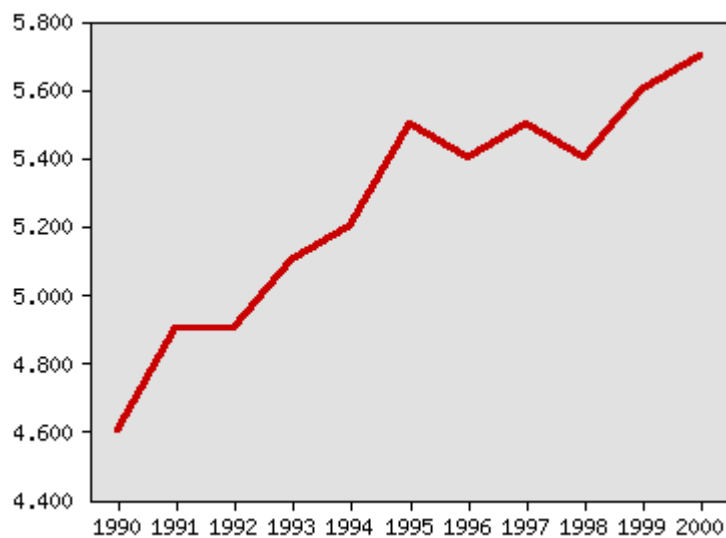
Year	
1990	5.9%
1991	6.3%
1992	5.3%
1993	5.5%
1994	6.4%
1995	6.7%
1996	6%
1997	6.7%
1998	5.8%
1999	6%
2000	5.8%



Data source: Minnesota Department of Health

Low birth weight babies, White (percent)

Year	
1990	4.6%
1991	4.9%
1992	4.9%
1993	5.1%
1994	5.2%
1995	5.5%



1996	5.4%
1997	5.5%
1998	5.4%
1999	5.6%
2000	5.7%

Data source: Minnesota Department of Health

About this indicator: The percentage of babies weighing less than 2,500 grams (or 5.5 pounds) at birth rose slightly during the past decade, from 5.1 in 1990 to 6.1 percent in 2000. The Minnesota Department of Health aims to decrease the frequency of low-weight births to no more than 3.5 percent of all births by 2004.

An increasing body of research shows that the period before birth is critical to growth and development. Low birth weight puts infants at higher risk for health problems, developmental delays and increased need of specialized medical, social, educational and other services. Babies are at higher risk of low birth weight if the mother smokes, is younger than 20 or older than 35, has less than 12 years of education, does not receive prenatal care, has poor nutrition or has a medical condition associated with low birth weight. Most cases of low birth weight are premature births (before 37 weeks).

Since 1990, the frequency of low-weight births has increased in the Asian/Pacific Islander, White and American Indian populations. It has changed very little among Hispanics and has decreased in the Black/African American population, from 13.7 percent in 1990 to 11.1 percent in 2000.

For comparison: Minnesota has fewer children with low birth weight than the national average. Nationwide, 7.6 percent of all babies had low birth weight in 2000, an increase from 7.0 percent in 1990. Nationally 6.5 percent of White babies, but 13.0 percent of Black/African American babies, had low birth weight.

Things to think about: The causes of low birth weight are not fully understood but experts believe that neighborhood-based care that is culturally sensitive and rooted in community values is a key factor in improving prenatal care.

Technical notes: The low birth weight figures reflect only those births for which a birth weight is reported. It may exclude some births, such as infants born at home. The figure includes multiple births, which are more likely to be of low birth weight than single births. Multiple births in Minnesota increased between 1980 and 1998. County data are provided in three year averages.

Sources:

- Minnesota Department of Health, Center for Health Statistics, www.health.state.mn.us
- Minnesota Department of Health, *Healthy Minnesotans: Minnesota Public Health Goals for 2004*, www.health.state.mn.us

- U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, www.cdc.gov/nchs
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INDICATOR 9 : ON-TIME IMMUNIZATION

Goal: *All children will be healthy and start school ready to learn.* The early childhood years – birth to age five – are a critical period of growth and development. Learning begins with a healthy, nurturing start in life. This goal reflects the growing scientific understanding that a healthy pregnancy and early nurturing contribute to a child's brain development and later success in school.

Rationale: On-time immunization is an important element in developing healthy children who can attend school every day, ready to learn.

About this indicator: On-time immunization for two-year-olds has risen steadily in the past decade, from 57.4 percent in 1988-89 to 81.7 percent in 2000-2001, an improvement of 24.3 percentage points. Yet even with 81.7 percent coverage in 2000-2001, 12,000 children were not up to date with immunizations at age two.

Immunization is particularly important during the first two years of life when children are most vulnerable to complications from disease. Timely immunization protects children against illness, disability and death from the infectious diseases of hepatitis, diphtheria, tetanus, polio, measles, mumps, rubella, pertussis, influenza and varicella (chickenpox). It is also an indicator of whether children are receiving regular well-child checkups.

Immunization records are collected from parents when children enter school; 2000-2001 data is for children born between 1994 and 1995. Thus the impact of any recent improvement is yet to be measured.

The Minnesota Department of Health goal for the year 2004 is for at least 90 percent of children to receive timely immunization against the 10 diseases mentioned above.

For comparison: According to the 2000-2001 National Immunization Survey, conducted by the U.S. Centers for Disease Control and Prevention, the immunization rate for Minnesota children is between two to four percentage points higher than national figures, for most major diseases.

Things to think about: Coverage is uneven across the state. In some ZIP codes in both urban and rural areas, almost half the children did not receive recommended immunizations on time. The data indicates that, although most Minnesota children start receiving immunizations at 4 months, many fall behind schedule and catch up only when it is time to start school. Immunization rates for varicella continue to lag behind those for the other target diseases.

In 1997, just 69 percent of Minneapolis public school students were up to date on their immunizations. The "No shots, no school" project was implemented that year and now over 98 percent of new and current students are properly immunized. Eighteen other Minnesota school districts now replicate this project.

Technical notes: Parents of children entering kindergarten must provide immunization records showing their children are in compliance with Minnesota's school immunization law. The data, therefore, is retrospective, based on immunizations given during the first two years of life. The data

presented in *Minnesota Milestones 2002* is based on random samples of schools, except for 1992-3 and 1996-7, when there were comprehensive surveys examining all kindergartners in the state.

Sources:

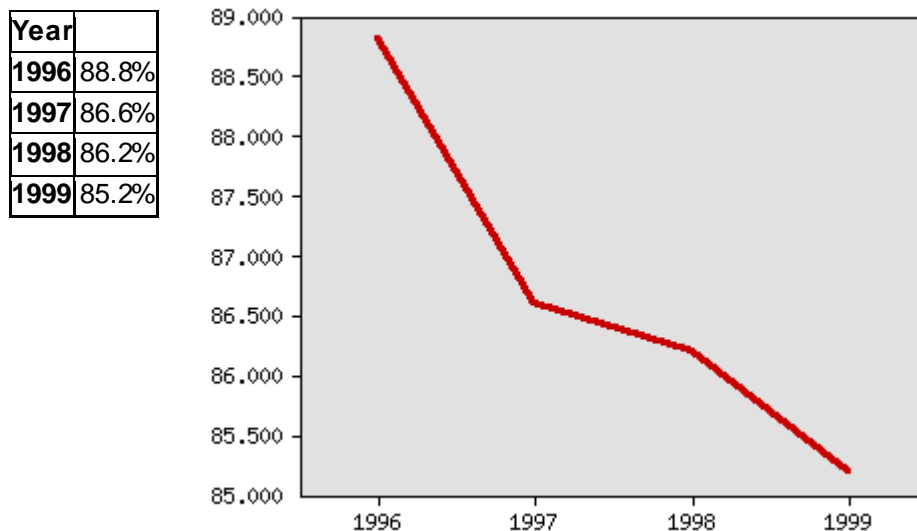
- Minnesota Department of Health, Acute Disease Prevention Services, *Retrospective Kindergarten Survey*, www.health.state.mn.us
- Minnesota Department of Health, *Healthy Minnesotans: Minnesota Public Health Improvement Goals*, June 1998
- U.S. Centers for Disease Control and Prevention, National Immunization Survey, www.cdc.gov

INDICATOR 1 0 : PRESCHOOL CHILD DEVELOPMENT

Goal: *All children will be healthy and start school ready to learn.* The early childhood years – birth to age five – are a critical period of growth and development. Learning begins with a healthy, nurturing start in life. This goal reflects the growing scientific understanding that a healthy pregnancy and early nurturing contribute to a child's brain development and later success in school.

Rationale: The developmental status of children just before they start school is a key indicator in showing progress toward this goal.

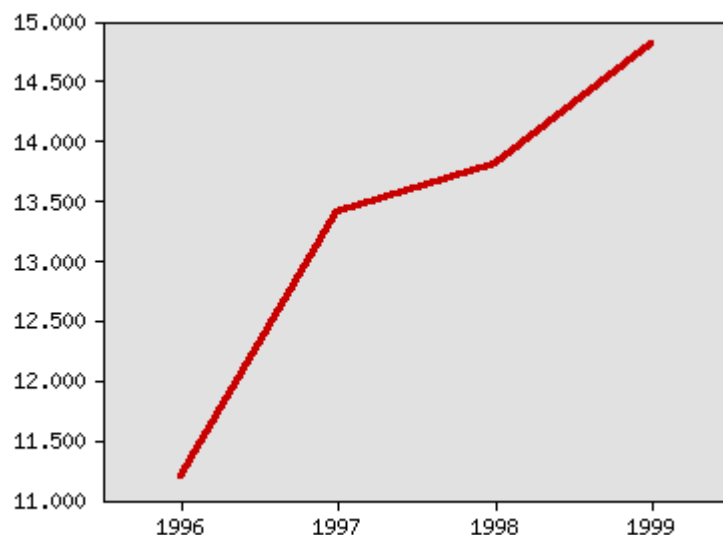
Percentage of children whose developmental skills are within normal ranges at early childhood screening



Data source: Minnesota Department of Children, Families & Learning

Percentage of children referred for further assessment following early childhood screening

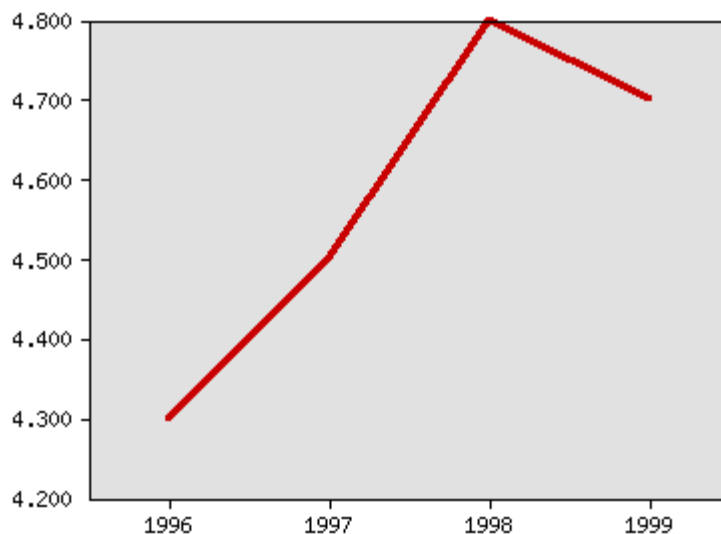
Year	
1996	11.2%
1997	13.4%
1998	13.8%
1999	14.8%



Data source: Minnesota Department of Children, Families & Learning

Percentage of children placed in special education following early childhood screening

Year	
1996	4.3%
1997	4.5%
1998	4.8%
1999	4.7%



Data source: Minnesota Department of Children, Families & Learning

About this indicator: The percentage of children assessed within the normal range decreased from 89 percent in 1996 to 85 percent in 1999.

Social, motor, cognitive, language and communication skills are all critical for children to get a good start in school. Minnesota requires screening of all children before they enter public school kindergarten, typically at age 3 to 4. According to the Minnesota Department of Children, Families & Learning, the purpose of early childhood screening is to detect conditions interfering with young

children's growth and development and improve access to preventive health services. It also aims to increase parents' awareness of the connections between physical health, development and learning readiness and to link families to community services.

Each screening includes height, weight, hearing, vision, developmental skills, immunization review, identification of risk factors that may influence learning and a summary review with parents.

While the decline in the percentage of children whose developmental skills are within normal ranges may be of concern, early referrals for further assessment or special education increases their chance to get the help they need. According to the Minnesota Department of Children, Families & Learning, the decline could be partially related to more thorough screening. The proportion of children placed in special education has increased by less than 1 percentage point since 1996, while the proportion of children referred for further assessment has increased by 3 percentage points.

For comparison: No comparable figures are available from other states.

Things to think about: While Minnesota requires all children to be screened for school readiness before entering kindergarten, the Minnesota Department of Children, Families & Learning would like more children to be screened earlier, since the sooner any issues are identified, the earlier children can receive help. [According to the Wilder Research Center, suburban children in the Twin Cities metro area are much more likely than central city children to be screened by age four.] The data excludes children screened through other sources such as Head Start and Child and Teen Checkup (Minnesota Early Periodic Screening Diagnosis and Treatment).

Technical notes: Most screening is carried out by school districts with state reimbursement of \$40 per child. The data excludes children screened through other sources such as Head Start and Child and Teen Checkup (Minnesota Early Periodic Screening Diagnosis and Treatment).

Sources:

- Minnesota Department of Children, Families & Learning, <http://cfl.state.mn.us>
- Wilder Research Center, *Metro Trend Watch*, www.metrotrendwatch.org

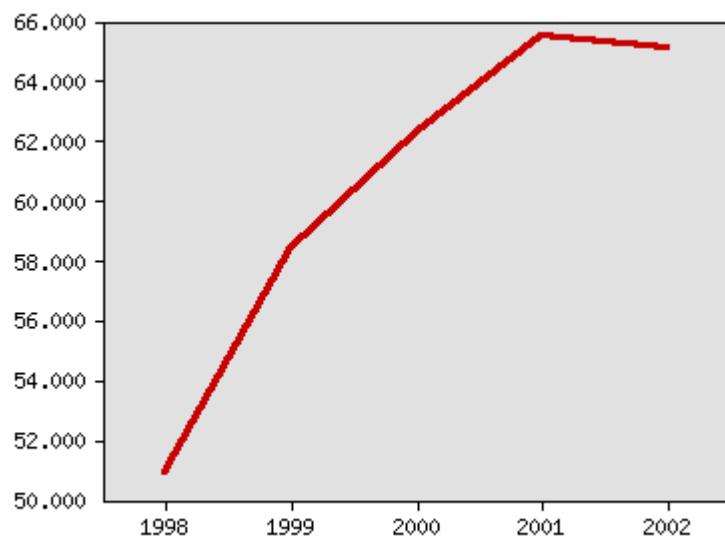
INDICATOR 1 1 : ELEMENTARY SCHOOL SKILLS

Goal: *Minnesotans will excel in basic and challenging academic skills and knowledge.* Minnesotans value an educated citizenry, well prepared for work and for participation in democracy and community life. The state now requires students to pass basic tests in reading, writing and mathematics in order to graduate from high school, and challenges them to meet the “high standards” of the Profile of Learning in 10 learning areas, ranging from science to the arts.

Rationale: The foundations of a good education are laid in the elementary school years when children are eager to learn and parents tend to be engaged in their children's learning.

Percentage of third-graders at level 2b, 3 or 4 on math exam

Year	
1998	50.9%
1999	58.4%
2000	62.3%
2001	65.5%
2002	65.1%

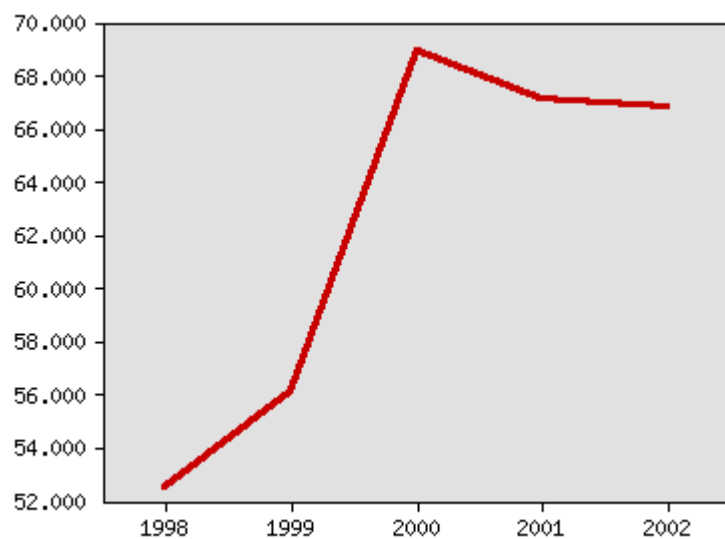


[Local data](#)

Data source: Minnesota Department of Children, Families & Learning

Percentage of third-graders at level 2b, 3 or 4 on reading exam

Year	
1998	52.5%
1999	56.1%
2000	68.9%
2001	67.1%
2002	66.8%

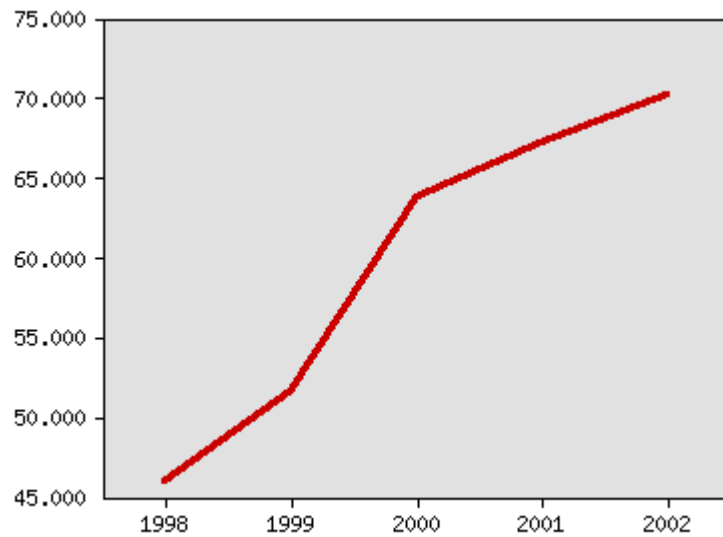


[Local data](#)

Data source: Minnesota Department of Children, Families & Learning

Percentage of fifth-graders at level 2b, 3 or 4 on math exam

Year	
1998	46%
1999	51.6%
2000	63.8%
2001	67.1%
2002	70.2%

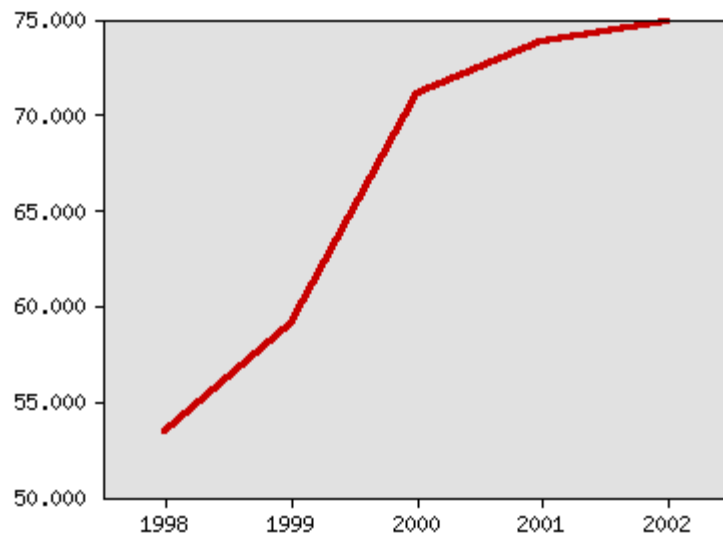


[Local data](#)

Data source: Minnesota Department of Children, Families & Learning

Percentage of fifth-graders at level 2b, 3 or 4 on reading exam

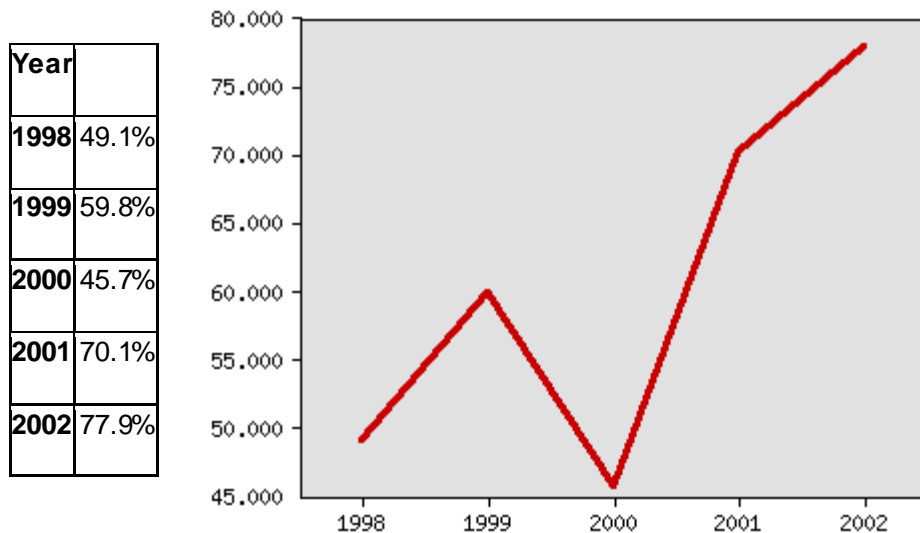
Year	
1998	53.4%
1999	59.1%
2000	71.1%
2001	73.8%
2002	74.8%



[Local data](#)

Data source: Minnesota Department of Children, Families & Learning

Percentage of fifth-graders at level 2b, 3 or 4 on writing



[Local data](#)

Data source: Minnesota Department of Children, Families & Learning

About this indicator: Scores on these tests have improved since they were started in 1997-98, for both third-graders and fifth-graders. The small drop in third grade math and reading scores in 2002 is not statistically significant. Students who score at levels 2b, 3 and 4 are demonstrating skills and knowledge at or above their grade level.

The greatest improvement has been in the fifth grade. Since 1998, the proportion of students performing at or above grade level has improved by 28.8 percent in writing, 24.2 percent in mathematics and 21.4 percent in reading. At 3rd grade level, improvement has also been encouraging, with an improvement of over 14 percent in the proportion of students performing at grade level between 1998 and 2002.

For comparison: The closest national benchmarks are the National Assessment of Educational Progress fourth-grade tests. In 1998, 36 percent of Minnesota students scored "proficient" or better in reading, compared to 29 percent nationally, ranking Minnesota eighth among the 40 participating states. In the 2000 mathematics test, 34 percent of Minnesota students scored "competent" or better, compared to 24 percent nationally, placing Minnesota first among 40 states.

Things to think about: These are not pass/fail tests, but are designed to assess whether the students are performing at their grade level and to determine whether they are on track to meet the "high standards" of the Profile of Learning when they reach high school. Schools use the results of these tests to adjust their curriculum and teaching.

Although Minneapolis and St. Paul students showed the greatest improvement on the tests from 2000 to 2002, a large gap remains between the central cities and the suburbs.

In 2000, the Minnesota Department of Children, Families and Learning commissioned an independent, nonpartisan, nonprofit organization, Achieve Inc., to study the quality and rigor of the Minnesota Comprehensive Assessments. Achieve's review found that on the whole, the tests are consistent with the content and skills of the Profile of Learning "high standards." They also made three recommendations to improve the next generation of Minnesota Comprehensive Assessments: communicate more clearly to teachers, students and test-makers what the state considers most essential for students to learn; revise the assessments to measure a broader range of standards, particularly the more challenging ones; and, increase the rigor of the tests.

Technical notes: Minnesota Comprehensive Assessments were mandated by the 1997 Legislature. Third-grade students are tested in mathematics and reading; fifth-grade students are tested in mathematics, reading and writing. All public schools must participate; private schools may participate voluntarily. Children who are absent for the tests do not have to complete them. Until 2002, scores in the Minnesota Comprehensive Assessments were reported publicly in four levels. They are now reported in five levels to more accurately reflect the division between students performing at grade level and those working below grade level. The 2002 Children's Report Card and Minnesota Milestones report the scores in five levels for all five years that the Minnesota Comprehensive Assessments have been in existence. Statewide and county level data are available. Results for each school are available on the Internet (<http://cfl.state.mn.us/grad/results.htm>).

Sources:

- Minnesota Department of Children, Families and Learning, <http://cfl.state.mn.us>
- U.S. Department of Education, National Assessments of Educational Progress, www.nces.ed.gov/nationsreportcard
- Achieve Inc., *Measuring Up: A Benchmarking Study of the Minnesota Comprehensive Assessments*, April 2001, www.achieve.org

INDICATOR 1 2 : EIGHTH-GRADE BASIC SKILLS

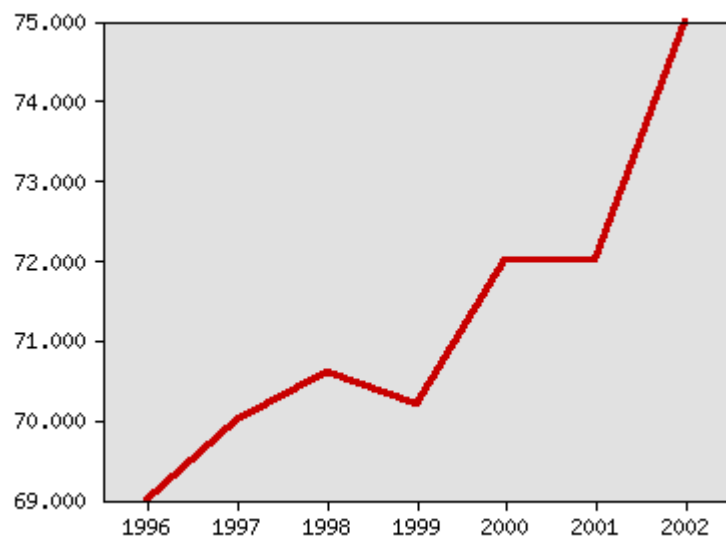
Goal: *Minnesotans will excel in basic and challenging academic skills and knowledge.* Minnesotans value an educated citizenry, well prepared for work and for participation in democracy and community life. The state now requires students to pass basic tests in reading, writing and mathematics in order to graduate from high school, and challenges them to meet the "high standards" of the Profile of Learning in 10 learning areas, ranging from science to the arts.

Rationale: The statewide Basic Standards Tests are designed to measure essential abilities needed to live and work in today's society.

Percentage of eighth-graders passing Basic Standards Math Test

Year	
1996	69%
1997	70%
1998	70.6%
1999	70.2%
2000	72%
2001	72%
2002	75%

[Local data](#)

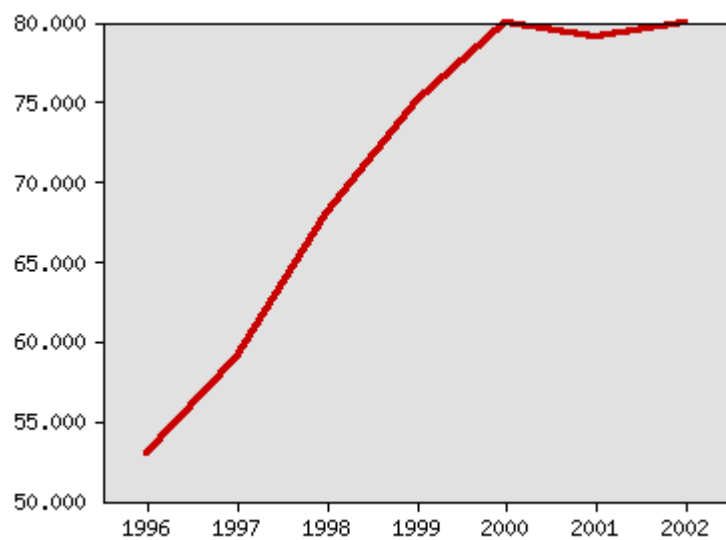


Data source: Minnesota Department of Children, Families & Learning

Percentage of eighth-graders passing Basic Standards Reading Test

Year	
1996	53%
1997	59%
1998	68.0%
1999	75%
2000	80%
2001	79%
2002	80.0%

[Local data](#)



Data source: Minnesota Department of Children, Families & Learning

About this indicator: Eighth-graders have shown dramatic improvement on these tests since their inception in 1995-96. Four out of five eighth-graders passed the reading test in 2001-02, compared to just over half in 1995-96. In mathematics, the pass rate improved from 69 percent in 1995-96 to 75 percent in 2001-2002. When the Basic Standards Tests first began, students had better success on the math test, however reading scores have made greater improvement in recent years.

These results show how many students pass the tests the first time, in the eighth grade. Those who do not pass can repeat the tests once a year through twelfth grade. They must pass in order to graduate from a Minnesota public high school. The difficulty level is considered equivalent to reading a newspaper and doing pre-algebra math.

The numbers here include most special education students and students with limited English proficiency who also take the tests. Accommodations, such as extra time or use of a computer, may be made for students with special educational needs. In reality, a minuscule number of Minnesota students do not graduate because of failing the Basic Standards Tests. Schools must provide help for students who otherwise might be unable to pass the test.

For comparison: The closest national benchmarks are the National Assessment of Educational Progress eighth-grade mathematics and reading tests. These assess the same skills, but at a higher level of competency. In the 1998 reading test, 37 percent of Minnesota students scored “proficient” or better, compared with 30 percent nationally, ranking Minnesota fourth among 36 participating states. In the 2000 mathematics test, 39 percent of Minnesota students scored proficient or better, compared with 26 percent nationally, placing Minnesota first among the 40 participating states.

Things to think about: A big gap remains between pass rates in the central cities and the rest of the state. In 2001-02, 48 percent of Minneapolis eighth-graders passed the math test; 53 percent passed the reading test. Forty-eight percent of St. Paul eighth-graders passed the math test and 55 percent passed in reading. However, the gap is narrowing slightly because of improvement in both districts.

There are differences statewide between lower-income and higher-income students on the basic standards tests, but this is more evident in St. Paul and Minneapolis. According to analysis by the Wilder Research Center, in the central cities higher-income students were about twice as likely to pass the test. Lower-income students fare better in the suburbs than in the central cities. Passing rates also differ by race: white students have the highest pass rate, black students the lowest. The differences in race are related to, but not fully explained by, family income levels.

Technical notes: Eighth grade Basic Skills tests were phased in during 1996 and 1997, when 78 percent of 8th graders participated. Since 1998, all students are required to take the tests. A score of 75 percent is required to pass the Basic Standards Tests. There is also a Basic Standards Test in writing that students must pass in order to graduate. That test begins in the tenth grade.

Sources:

- Minnesota Department of Children, Families & Learning, <http://cfl.state.mn.us>
 - Wilder Research Center, Metro Trend Watch 2001, www.metrotrendwatch.org
 - U.S. Department of Education, National Assessments of Educational Progress, www.nces.ed.gov/nationsreportcard
-

INDICATOR 1 3 : COLLEGE ENTRANCE SCORES

Goal: *Minnesotans will excel in basic and challenging academic skills and knowledge.* Minnesotans value an educated citizenry, well prepared for work and for participation in democracy and community life. The state now requires students to pass basic tests in reading, writing and mathematics in order to graduate from high school, and challenges them to meet the “high standards” of the Profile of Learning in 10 learning areas, ranging from science to the arts.

Rationale: Average ACT scores provide one of the best available indicators of students' broad, advanced skills and knowledge near high school graduation.

About this indicator: The average score rose slightly between 1991 and 1996 and has held fairly steady since then. At the same time, many more students are taking the ACT – 66 percent of graduating students in 2001, compared to 35 percent in the late 1980s. In 2000, 92 percent of Minnesota students taking the ACT test were White, four percent were Asian/Hispanic Islander, two percent were Black/African American, one percent were Hispanic and less than one percent were American Indian.

The ACT test measures reasoning and thinking skills in English, mathematics, reading and science. A perfect score is 36 and many top colleges prefer a score of 28 or higher.

For comparison: The average national score has remained constant for five years at 21.0. Comparison among states is difficult because in some states college-bound students take the SAT test, not the ACT. In 2001, Minnesota ranked second, behind Wisconsin, among states where more than half of graduating seniors took the ACT test.

Things to think about: The recommended study in preparation for the ACT is four years of English and three years each of science, social science and mathematics. In 2001, 67 percent of Minnesota students taking the ACT had taken this recommended college preparation curriculum, compared to 71 percent of test-takers four years earlier. In 2001, Minnesota students who took the recommended college preparatory classes scored an average of 2.5 points higher than students who did not.

Technical notes: ACT tests are held five to six times a year. Parents and students determine when the test is taken. In practice most students take the ACT test at the end of their junior year or the beginning of their senior year; it can be retaken.

Sources:

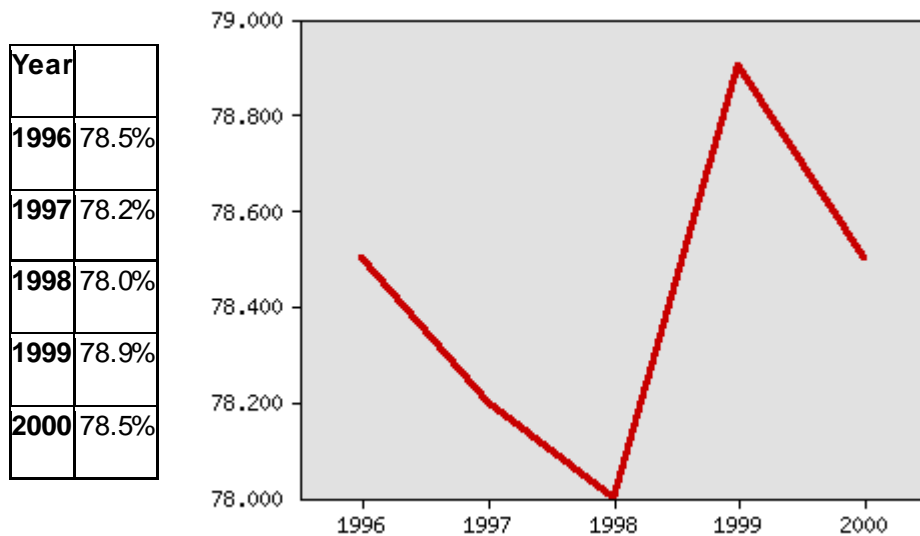
- ACT Inc., www.act.org ACT High School profile for Minnesota Graduating Class 2000

INDICATOR 1 4 : HIGH SCHOOL GRADUATION

Goal: *Minnesotans will excel in basic and challenging academic skills and knowledge.* Minnesotans value an educated citizenry, well prepared for work and for participation in democracy and community life. The state now requires students to pass basic tests in reading, writing and mathematics in order to graduate from high school, and challenges them to meet the “high standards” of the Profile of Learning in 10 learning areas, ranging from science to the arts.

Rationale: A high school diploma is a sign of basic academic competence. It is generally considered a minimum requirement for entry into the workforce and is an essential prerequisite for additional education and training.

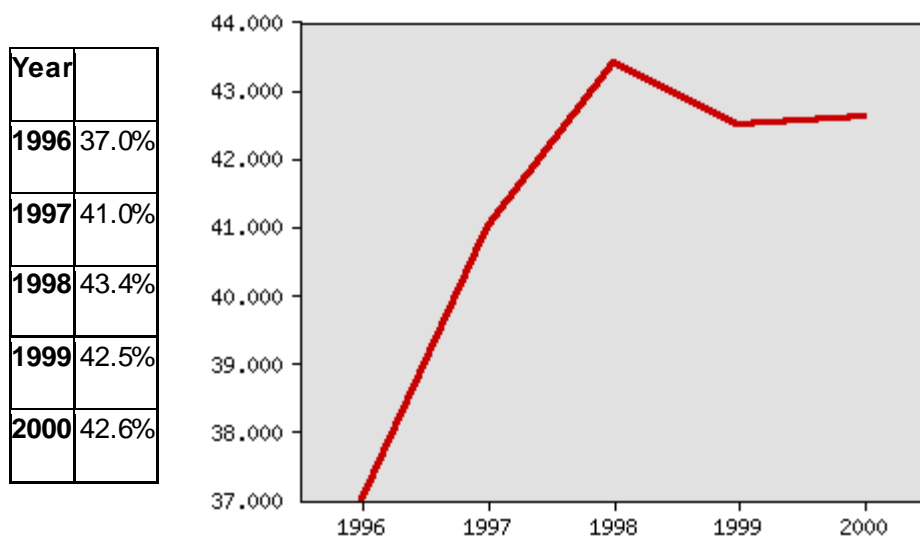
Public school ninth-graders who four years later graduated, total (percent)



[Local data](#)

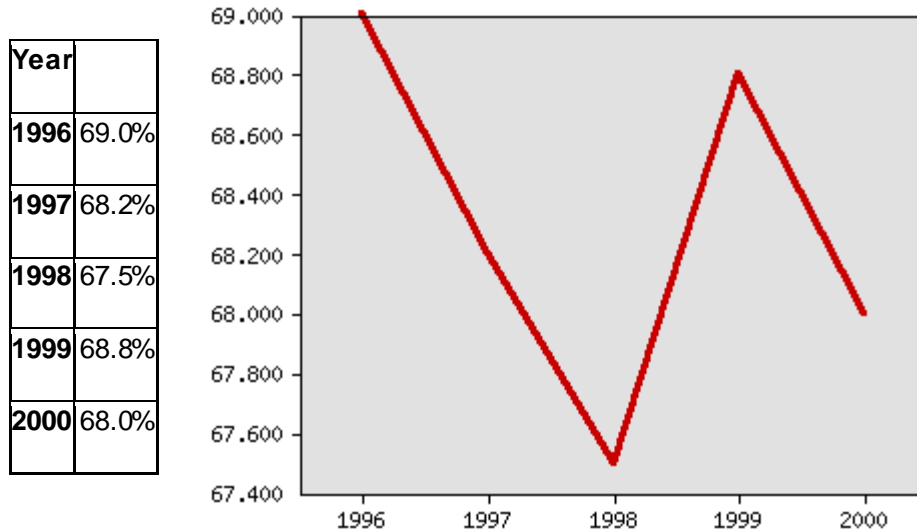
Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later graduated, American Indian (percent)



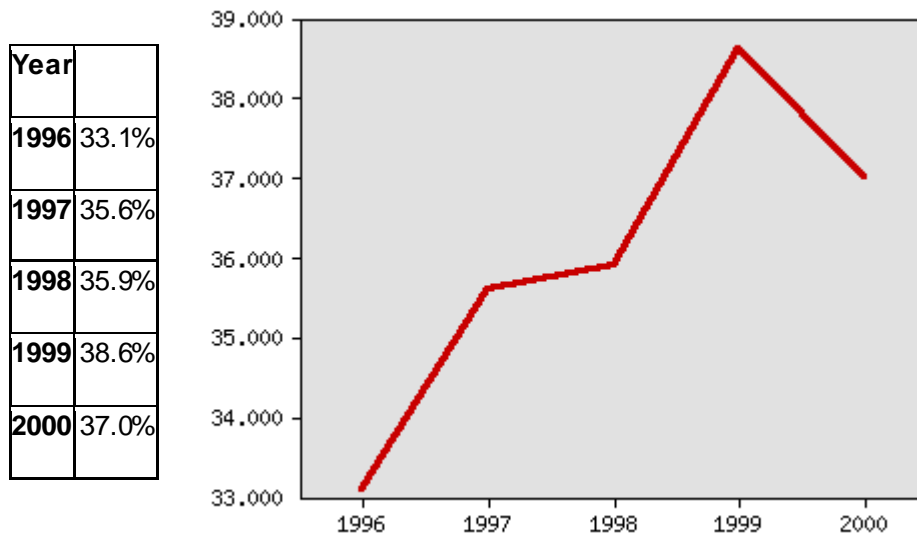
Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later graduated, Asian or Pacific Islander (percent)



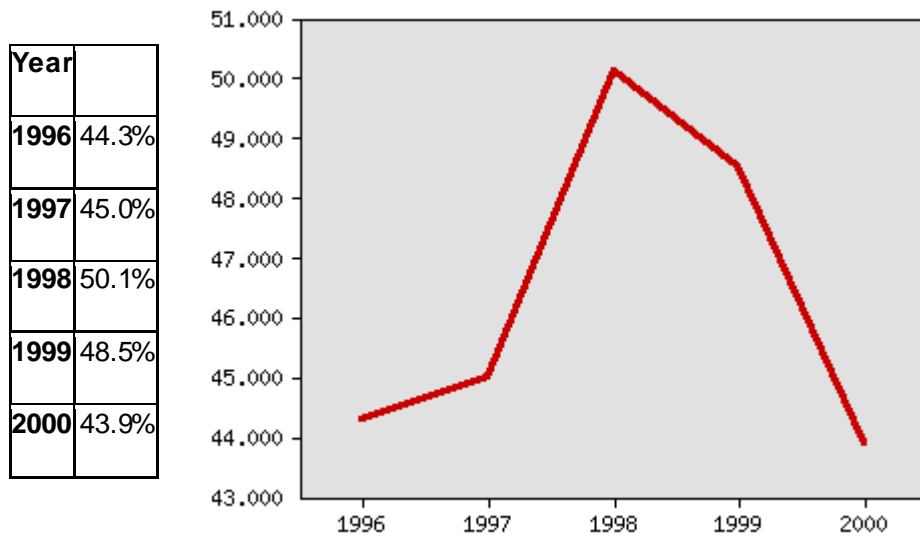
Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later graduated, Black/ African American (percent)



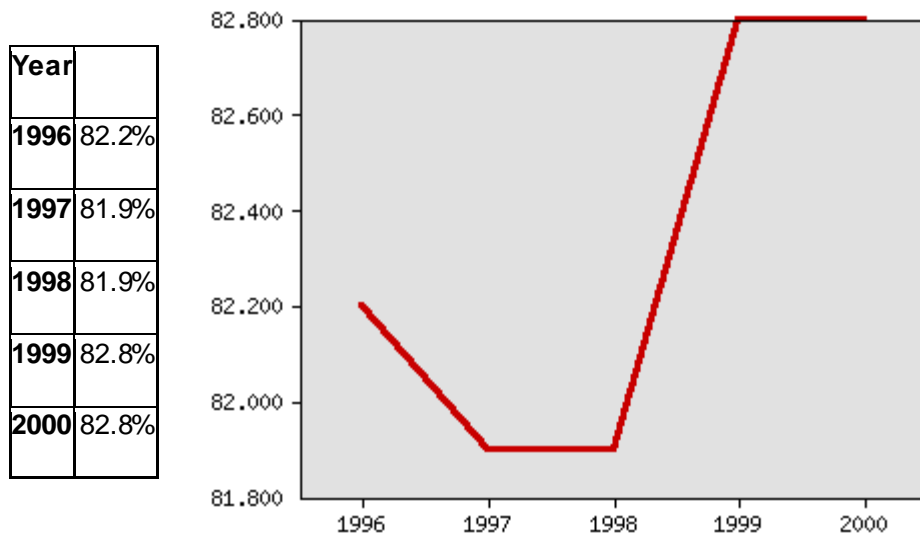
Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later graduated, Hispanic (percent)



Data source: Minnesota Department of Children, Families & Learning

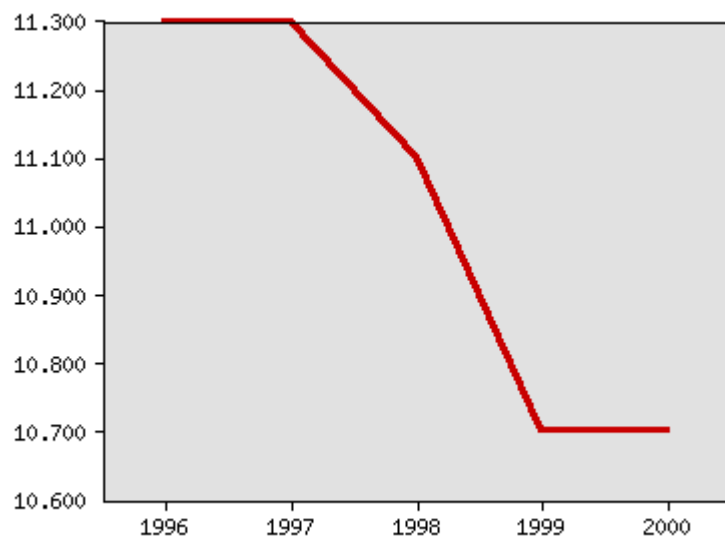
Public school ninth-graders who four years later graduated, White (percent)



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later dropped out, total (percent)

Year	
1996	11.3%
1997	11.3%
1998	11.1%
1999	10.7%
2000	10.7%

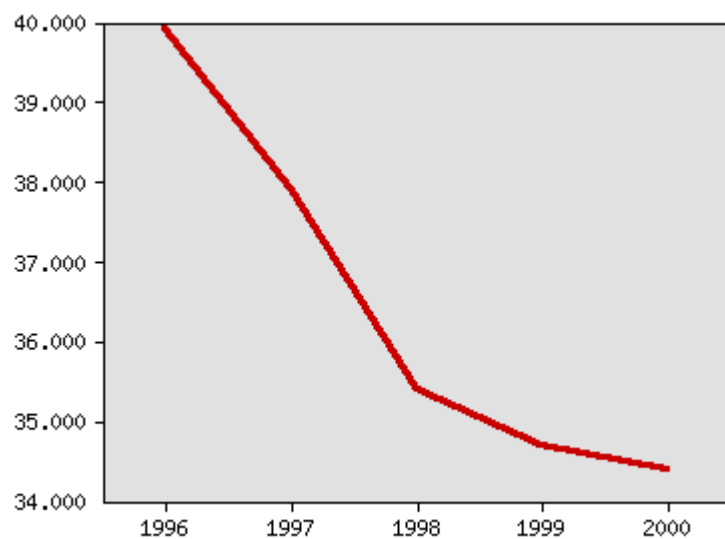


[Local data](#)

Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later dropped out, American Indian (percent)

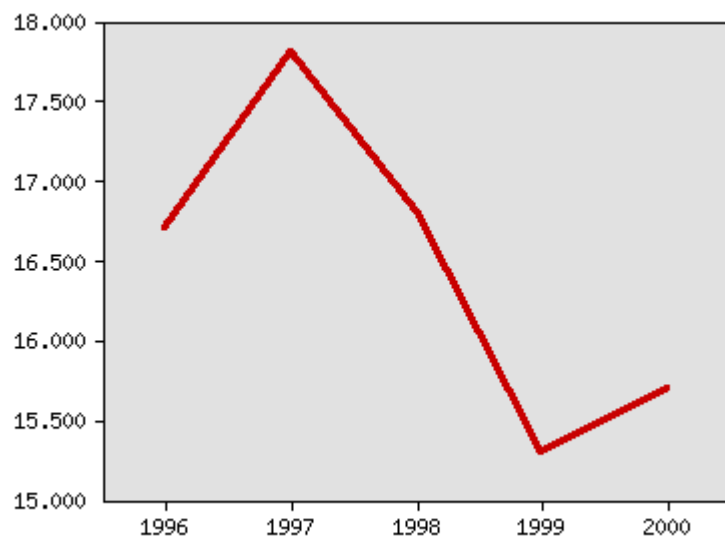
Year	
1996	39.9%
1997	37.9%
1998	35.4%
1999	34.7%
2000	34.4%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later dropped out, Asian or Pacific Islander (percent)

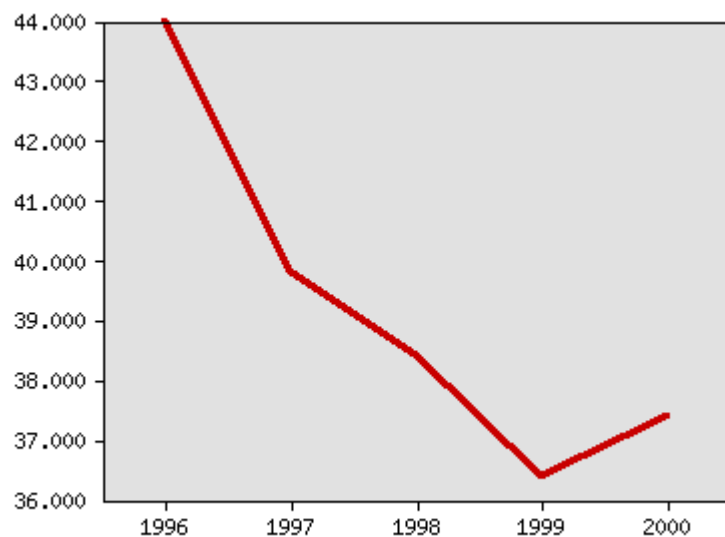
Year	
1996	16.7%
1997	17.8%
1998	16.8%
1999	15.3%
2000	15.7%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later dropped out, Black/ African American (percent)

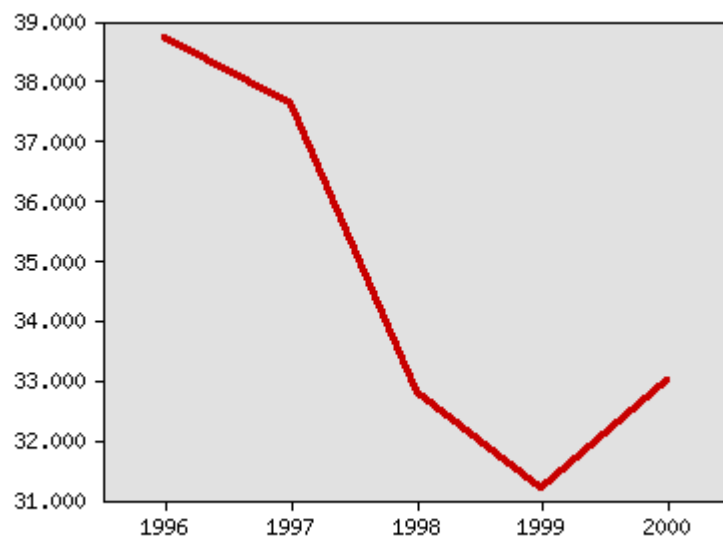
Year	
1996	44.0%
1997	39.8%
1998	38.4%
1999	36.4%
2000	37.4%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later dropped out, Hispanic (percent)

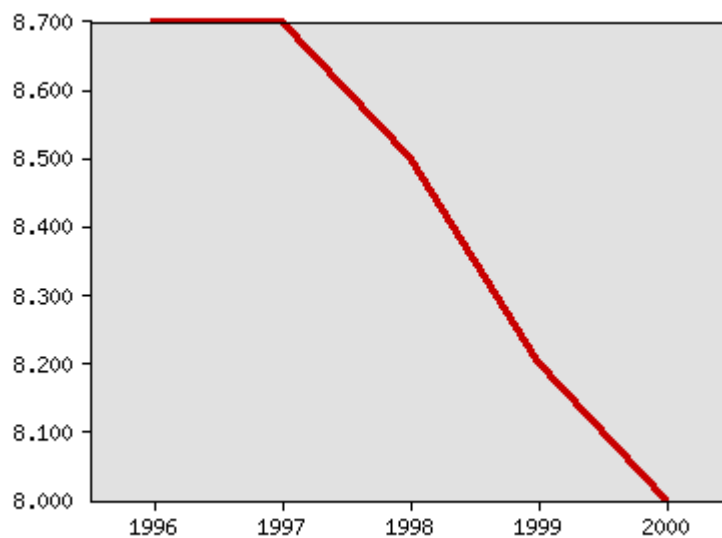
Year	
1996	38.7%
1997	37.6%
1998	32.8%
1999	31.2%
2000	33.0%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later dropped out, White (percent)

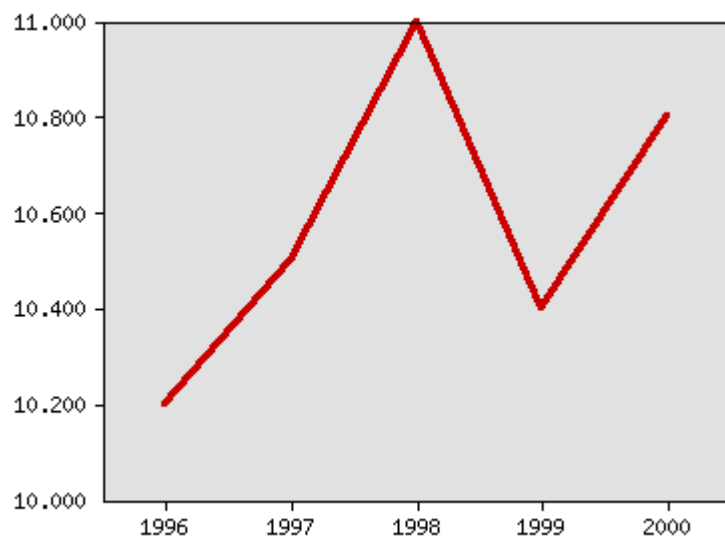
Year	
1996	8.7%
1997	8.7%
1998	8.5%
1999	8.2%
2000	8.0%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later continued, total (percent)

Year	
1996	10.2%
1997	10.5%
1998	11.0%
1999	10.4%
2000	10.8%

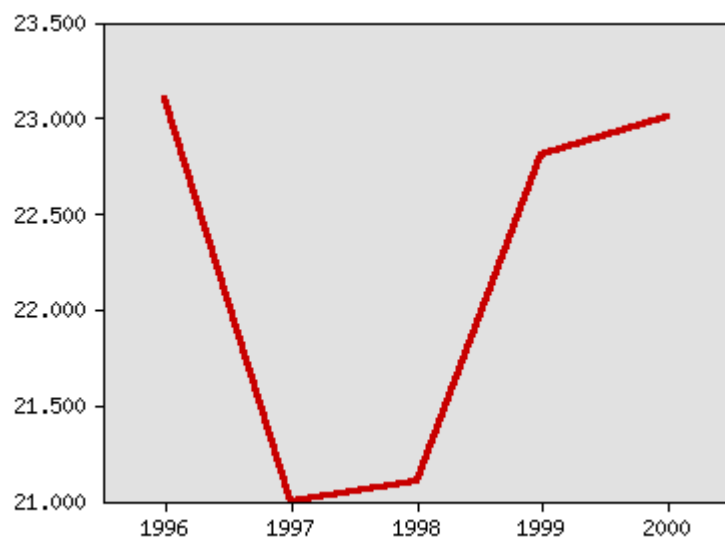


[Local data](#)

Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later continued, American Indian (percent)

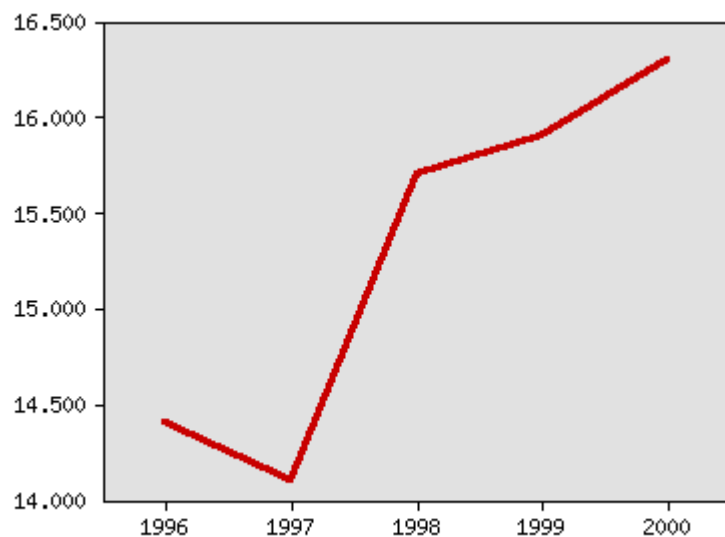
Year	
1996	23.1%
1997	21.0%
1998	21.1%
1999	22.8%
2000	23.0%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later continued, Asian or Pacific Islander (percent)

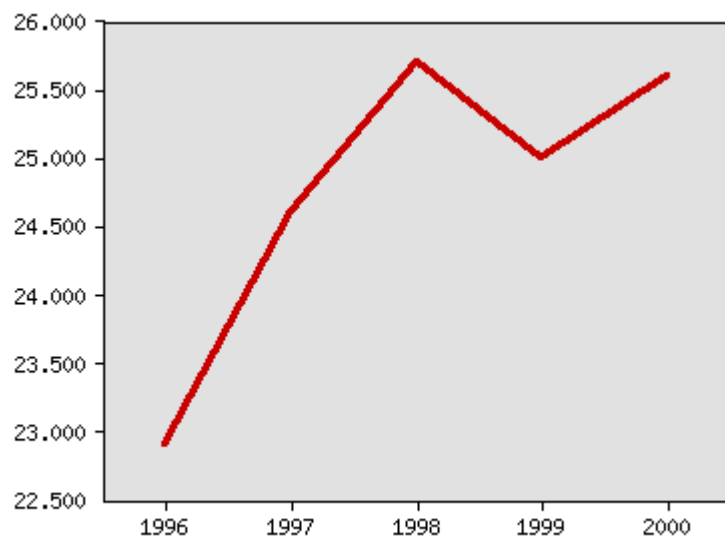
Year	
1996	14.4%
1997	14.1%
1998	15.7%
1999	15.9%
2000	16.3%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later continued, Black/ African American (percent)

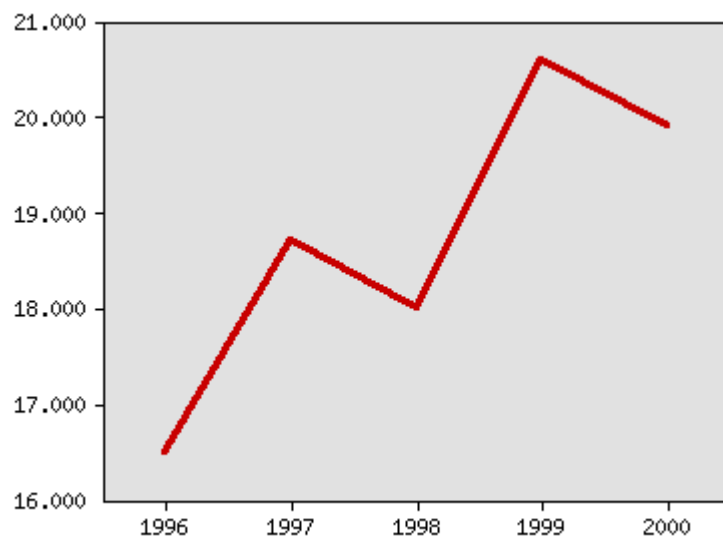
Year	
1996	22.9%
1997	24.6%
1998	25.7%
1999	25.0%
2000	25.6%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later continued, Hispanic (percent)

Year	
1996	16.5%
1997	18.7%
1998	18.0%
1999	20.6%
2000	19.9%



Data source: Minnesota Department of Children, Families & Learning

Public school ninth-graders who four years later continued, White (percent)

Year	
1996	9.1%
1997	9.3%
1998	9.7%
1999	9.0%
2000	9.2%



Data source: Minnesota Department of Children, Families & Learning

About this indicator: There has been no significant change since 1996 in the percentage of public school ninth-graders who four years later graduate, continue in school or have dropped out. There has been a marked consistency in recent years in the percentage of ninth-graders who graduate four years later. Between 1996 and 2000, the percentage has floated between 78 and 79 percent.

Graduation rates vary widely among different racial and ethnic groups. While in 2000 83 percent of white students graduated on time, the rates were much lower for all other racial and ethnic groups:

- 68 percent of Asian/Pacific Islander students (same as 1996)
- 47 percent of Hispanic students (up from 45 percent in 1996)
- 43 percent of American Indians (up from 37 percent in 1996)
- 37 percent of Black/African American students (up from 33 percent in 1996)

Substantial numbers of students of color do continue in high school beyond four years and eventually graduate.

For comparison: Minnesota is one of only a few states to track students over four years in this way. Direct comparison with other states' published figures on high school graduation may therefore be misleading.

The National Center for Education Statistics reports the percentage of 18- to 24-year-olds who have completed high school. Nationally, the three-year average for 1998-2000 was 85.7 percent. Minnesota ranked sixth among all 50 states at 91.9 percent, behind Alaska, Maine, Missouri and North and South Dakota.

Things to think about: Gender and family income are also linked to graduation rates, although the differences are not as drastic as those by race/ethnicity. In 1999-2000, the graduation rate was higher for girls, 82 percent, than for boys, 75 percent. Only 61 percent of lower-income students (eligible for free or reduced-price lunch) graduated on time in 1999-2000, compared to 84 percent of students not eligible for free or reduced-price meals.

Technical notes: The Minnesota graduation statistics track only students who stay in the same school district from the ninth grade on. This excludes students who have dropped out before ninth grade and those who enter a school district after ninth grade. Students who graduated in 2000 were the first required to pass Minnesota's Basic Standards Tests in reading and math. Beginning in 2001, graduates were also required to pass a statewide writing test. There is no evidence that this has affected graduation rates.

Sources:

- Minnesota Department of Children, Families & Learning, *Completion Study for the Class of 2000*, <http://cfl.state.mn.us>,
- U.S. Department of Education, National Center for Education Statistics, Common Core Data, www.nces.ed.gov

INDICATOR 1 5 : HEALTH INSURANCE

Goal: *Minnesotans will be healthy.* This goal encompasses both physical and mental health throughout life. It is also aimed at reducing disparities in health status among racial and ethnic minorities. Indicators for the goal deal with both health status and health care.

Rationale: Health insurance coverage is a good indicator of progress toward the goal because it increases the likelihood that people will get the preventive care and treatment they need to stay healthy.

About this indicator: Health insurance coverage levels have changed very little in the past decade, fluctuating between 90 and 92 percent. The Minnesota Department of Health has a goal of full insurance coverage, including preventive services, for every Minnesotan by 2004. In 2001, the Minnesota Legislature allocated \$13.9 million for a statewide health disparities initiative.

The survey that provides these statistics does not differentiate between full coverage and insurance that covers only major illness and hospitalization. People with inadequate insurance or no insurance often forgo routine preventive care.

For comparison: At 91 percent, Minnesota ranked second behind Rhode Island for health insurance coverage in 1999-2000. The national two-year average was 86 percent. For the years 1999-2000, 92 percent of Minnesota children were insured, compared to a national average of 88 percent.

Things to think about: In the United States, most health insurance comes through employment. Others are covered by government programs such as Medicare, Medicaid, MinnesotaCare and military health care.

Groups with lower insurance coverage include lower-income people, those born outside the United States, and young adults age 18 to 24. Health insurance rates among those born outside the United States increase with length of residence and citizenship.

In 2000 the University of Minnesota's School of Public Health was awarded a three-year, \$4 million federal grant to help states nationwide assess their insurance needs. More detailed information about the characteristics of the uninsured should help policy-makers target interventions more effectively.

Technical notes: Survey respondents are considered to have insurance coverage if they were covered by either private insurance or government programs such as Medicare or MinnesotaCare at any time during the year. Because of small sample sizes and possible errors in annual state-level estimates, two-year averages are used.

Since 1990 the Health Department has used the Minnesota Health Access Survey, an annual telephone poll, to track uninsurance rates in the state. Minnesota Milestones uses the Current Population Survey (CPS) based on annually updated census information.

The rate of change reported in these two surveys has been very similar, but the absolute uninsurance rates reported from the CPS and the Minnesota Health Access Survey are different because the surveys use different definitions of uninsurance. The CPS uninsurance rate is a measure of the percent of people uninsured at some time during the previous year. The uninsurance rate from the Minnesota Health Access Survey is a measure of the percent of people uninsured at the time of the survey. Over time, the CPS uninsurance rate has consistently been about 50% higher than the uninsurance rate from the Minnesota Health Access Survey.

Sources:

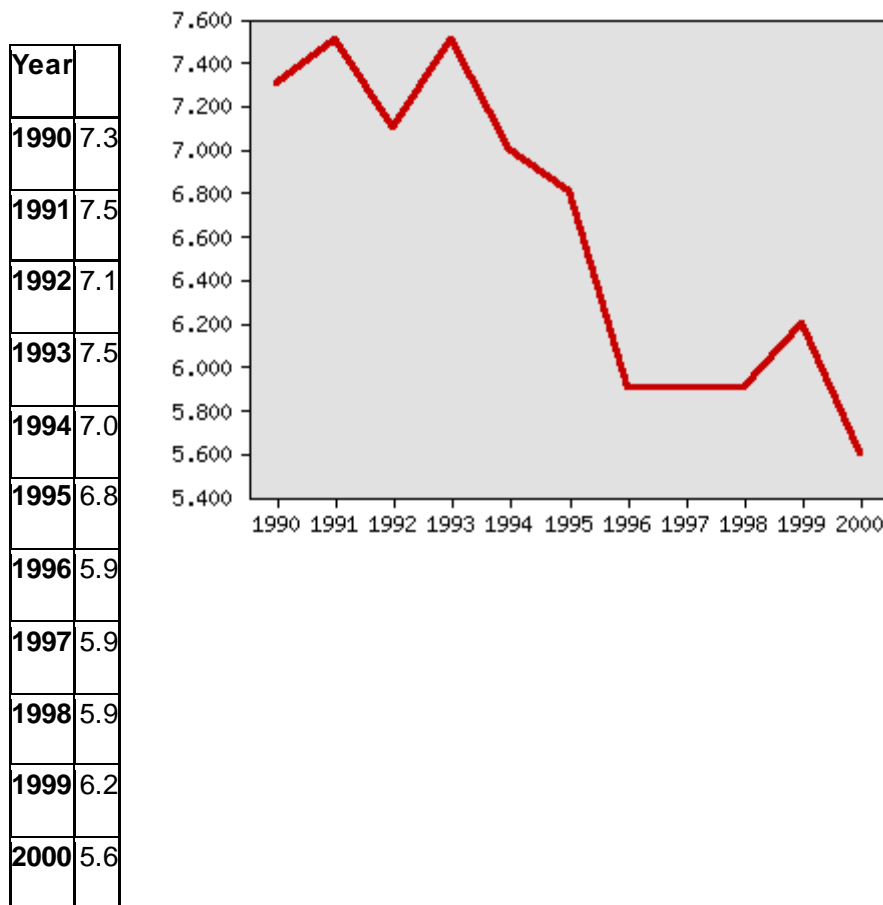
- U.S. Bureau of the Census, Current Population Reports, *Health Insurance Coverage*, September 2001, www.census.gov
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INDICATOR 1 6 : INFANT MORTALITY

Goal: *Minnesotans will be healthy.* This goal encompasses both physical and mental health throughout life. It is also aimed at reducing disparities in health status among racial and ethnic minorities. Indicators for the goal deal with both health status and health care.

Rationale: Infant mortality is an important indicator because it reflects the quality of both pre- and post-natal care.

Infant mortality rate per 1,000 live births, total

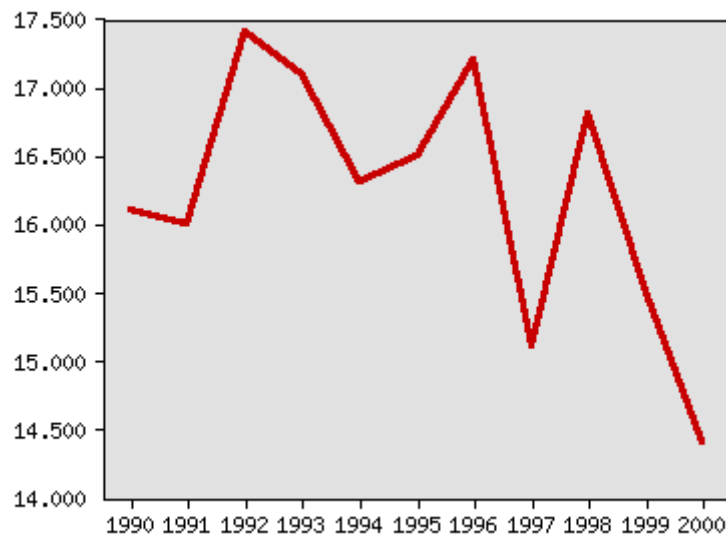


[Local data](#)

Data source: Minnesota Department of Health

Infant mortality rate per 1,000 live births, American Indian

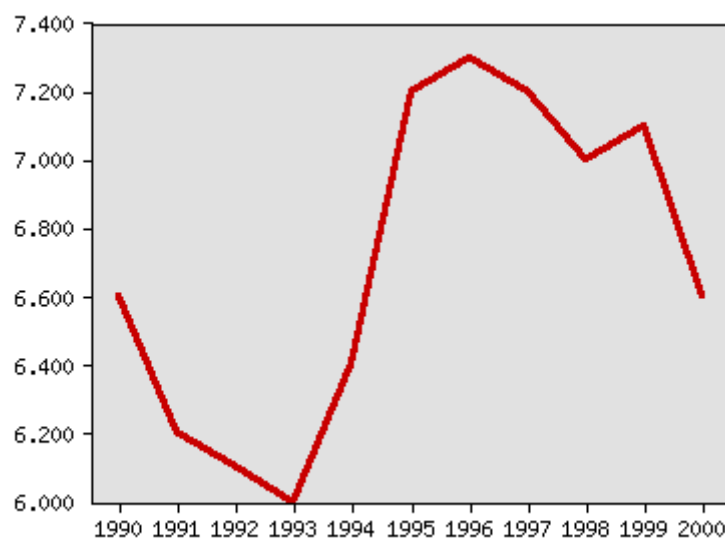
Year	
1990	16.1
1991	16.0
1992	17.4
1993	17.1
1994	16.3
1995	16.5
1996	17.2
1997	15.1
1998	16.8
1999	15.5
2000	14.4



Data source: Minnesota Department of Health

Infant mortality rate per 1,000 live births, Asian or Pacific Islander

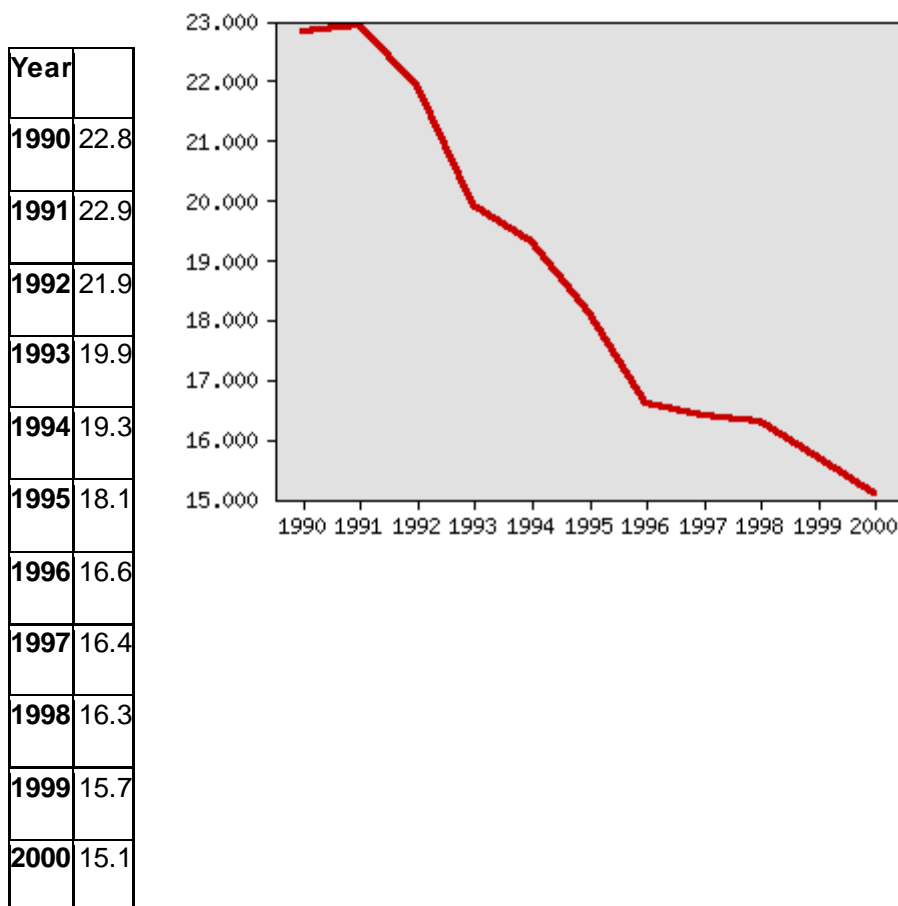
Year	
1990	6.6
1991	6.2
1992	6.1
1993	6.0
1994	6.4
1995	7.2



1996	7.3
1997	7.2
1998	7.0
1999	7.1
2000	6.6

Data source: Minnesota Department of Health

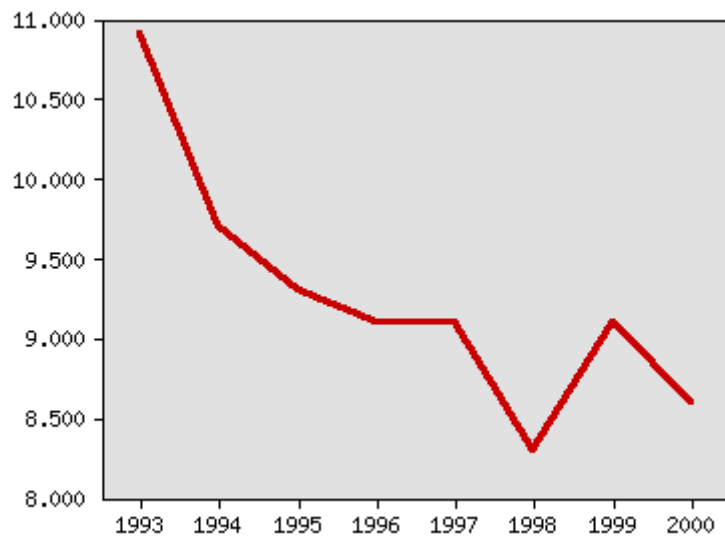
Infant mortality rate per 1,000 live births, Black/ African American



Data source: Minnesota Department of Health

Infant mortality rate per 1,000 live births, Hispanic

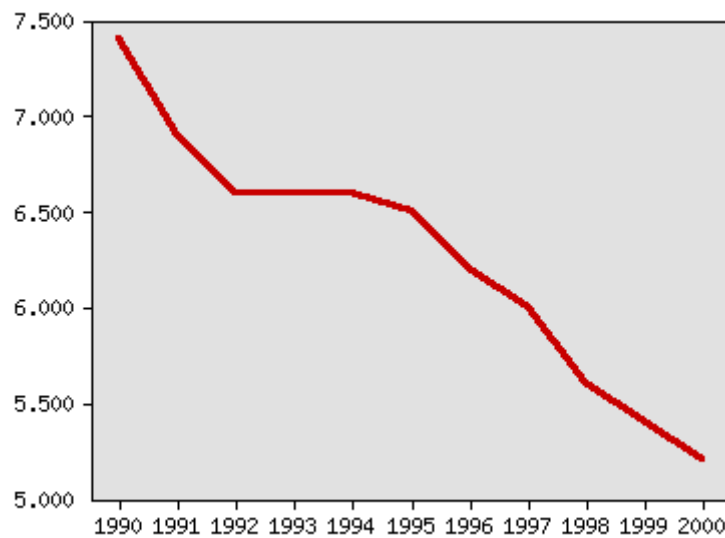
Year	
1993	10.9
1994	9.7
1995	9.3
1996	9.1
1997	9.1
1998	8.3
1999	9.1
2000	8.6



Data source: Minnesota Department of Health

Infant mortality rate per 1,000 live births, White

Year	
1990	7.4
1991	6.9
1992	6.6
1993	6.6
1994	6.6
1995	6.5
1996	6.2
1997	6.0
1998	5.6



1999	5.4
2000	5.2

Data source: Minnesota Department of Health

About this indicator: The number of infant deaths per 1,000 live births declined steadily from 7.5 in 1993 to 5.6 in 2000 apart from a slight increase in 1999. The Minnesota Department of Health has set a goal of reducing the infant mortality rate to no more than five deaths per 1,000 live births by 2004. In 2001, the Minnesota Legislature allocated \$13.9 million for a statewide health disparities initiative.

Among racial groups, the most dramatic improvement was in Black/African American infant mortality, which dropped from 22.8 to 15.1 between 1990-2000. However, infant mortality rates for Blacks/African Americans, American Indians and Hispanics remain well above rates for Whites.

For comparison: Nationally, the infant mortality rate was 7.3 deaths per 1,000 live births in 1999, compared to the Minnesota rate of 6.2 per 1,000.

Things to think about: Medical advances in the care of very premature infants have improved survival rates over the past decade. However, this indicator reveals one of Minnesota's worst health discrepancies between White children and children of color. The state's infant mortality rates for Black/African American and Native American children are among the highest in the country. In the Twin Cities metropolitan area, the mortality rate is four times greater for Black/African American infants than for White infants.

Technical notes: Infant mortality is reported as the number of deaths from birth to the first birthday, per 1,000 live births. Rates for racial and ethnic groups are an aggregate for the preceding five-year period. County rates are in three year averages.

Sources:

- Minnesota Department of Health, www.health.state.mn.us
- U.S. Centers for Disease Control and Prevention, *National Vital Statistics Report*, www.cdc.gov/nchs

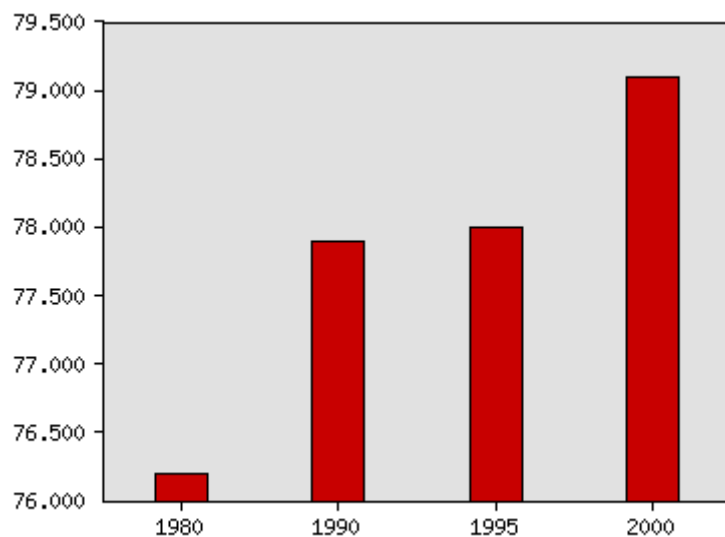
INDICATOR 1 7 : LIFE EXPECTANCY

Goal: *Minnesotans will be healthy.* This goal encompasses both physical and mental health throughout life. It is also aimed at reducing disparities in health status among racial and ethnic minorities. Indicators for the goal deal with both health status and health care.

Rationale: Life expectancy is used worldwide as a broad snapshot of human health.

Expected years of life remaining at birth

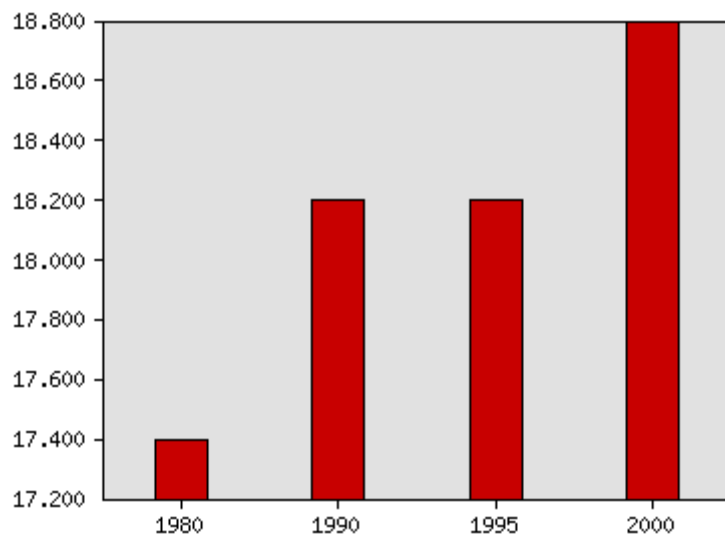
Year	
1980	76.2
1990	77.9
1995	78.0
2000	79.1



Data source: National Center for Health Statistics and State Demographic Center at Minnesota Planning

Expected years of life remaining at age 65

Year	
1980	17.4
1990	18.2
1995	18.2
2000	18.8



Data source: National Center for Health Statistics and State Demographic Center at Minnesota Planning

About this indicator: Since 1980, the life expectancy for Minnesota newborns has increased by almost three years and for 65-year-olds by 1.4 years. Life expectancy takes into account all causes of death at any point after birth.

Minnesota women have a longer life expectancy at birth than men, but the gap narrowed from 7.3 years in 1980 to 5.0 years in 2000. At age 65 the gap is smaller at 3.4 years.

Minnesota's long life expectancy is not shared equally by all racial and ethnic groups. In 1990, the life expectancy of Blacks/African Americans and American Indians fell far short of life expectancy for Whites. In 2001, the Minnesota Legislature allocated \$13.9 million for a statewide health disparities initiative.

Data for life expectancy is calculated periodically from population and mortality rates.

For comparison: In 1995, the U.S. average life expectancy was 75.8 years at birth (compared to 78 in Minnesota) and 17.4 years at age 65 (compared to 18.2 in Minnesota). By 1999, the national figures increased slightly to 76.7 and 17.7, respectively. Minnesota data is not available for 1999.

Things to think about: In 1999, accidents (primarily motor vehicle) were the leading cause of death for Minnesotans under age 34. Between ages 15 and 34, the second leading cause of death was suicide. From ages 35 to 74, the largest number of deaths were from cancer. After the age of 75, heart disease was the leading cause of death.

Technical notes: Population rates are collected by the Census, which takes place every ten years; mortality data is released annually.

Sources:

- The State Demographic Center at Minnesota Planning, publication forthcoming, www.mnplan.state.mn.us
- U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Report, www.cdc.gov/nchs

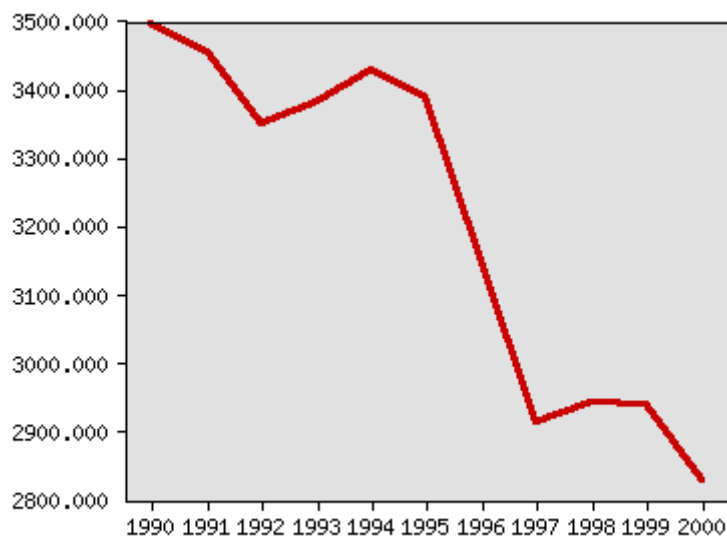
INDICATOR 1 8 : PREMATURE DEATH

Goal: *Minnesotans will be healthy.* This goal encompasses both physical and mental health throughout life. It is also aimed at reducing disparities in health status among racial and ethnic minorities. Indicators for the goal deal with both health status and health care.

Rationale: Statistics on premature death give an indication of lives cut short by illness or injury.

Years of potential life lost before age 65, per 100,000 people

Year	
1990	3,495.0
1991	3,454.8
1992	3,348.1
1993	3,381.6
1994	3,428.1
1995	3,386.8
1996	3,147.2
1997	2,912.6
1998	2,941.8
1999	2,939.1
2000	2,828.8

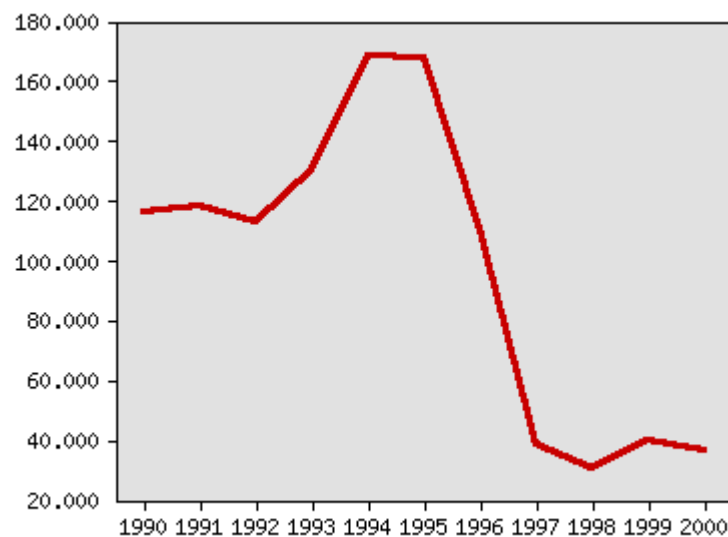


[Local data](#)

Data source: Minnesota Department of Health

Years of potential life lost before age 65 to AIDS-HIV, per 100,000 people

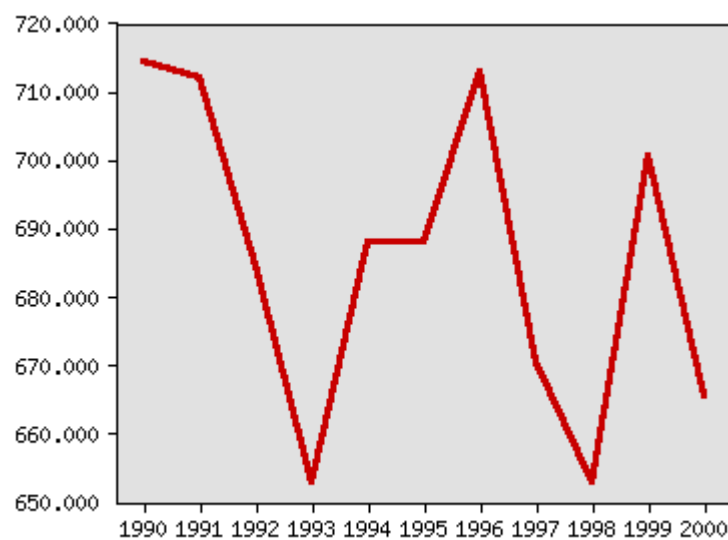
Year	
1990	115.8
1991	117.9
1992	112.5
1993	130.4
1994	168.3
1995	167.9
1996	109.9
1997	38.7
1998	30.4
1999	39.7
2000	36.2



Data source: Minnesota Department of Health

Years of potential life lost before age 65 to cancer, per 100,000 people

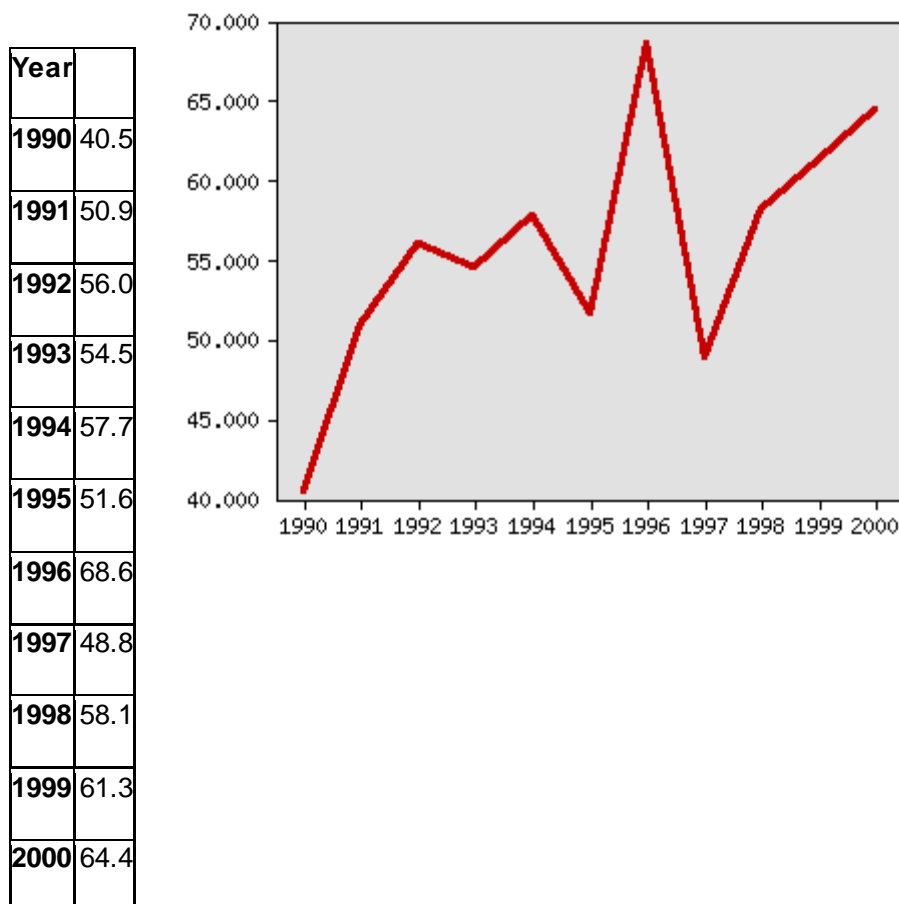
Year	
1990	714.4
1991	712.0
1992	684.4
1993	652.9
1994	687.9
1995	687.8



1996	712.8
1997	670.5
1998	652.7
1999	700.4
2000	665.5

Data source: Minnesota Department of Health

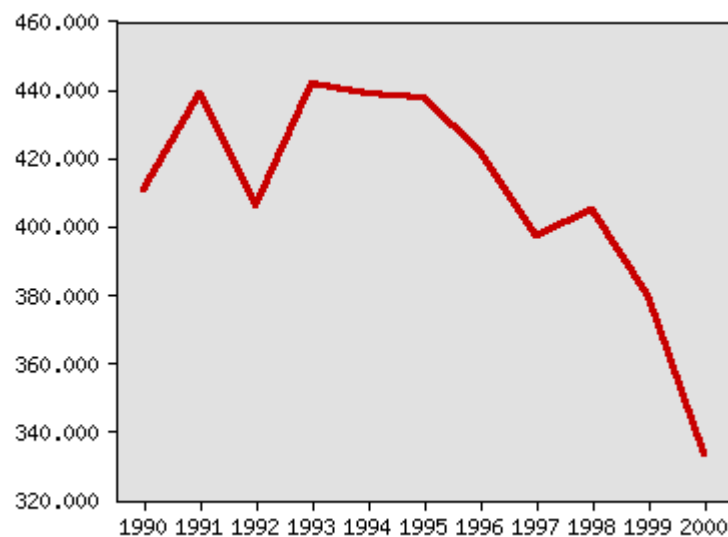
Years of potential life lost before age 65 to diabetes, per 100,000 people



Data source: Minnesota Department of Health

Years of potential life lost before age 65 to heart disease, per 100,000 people

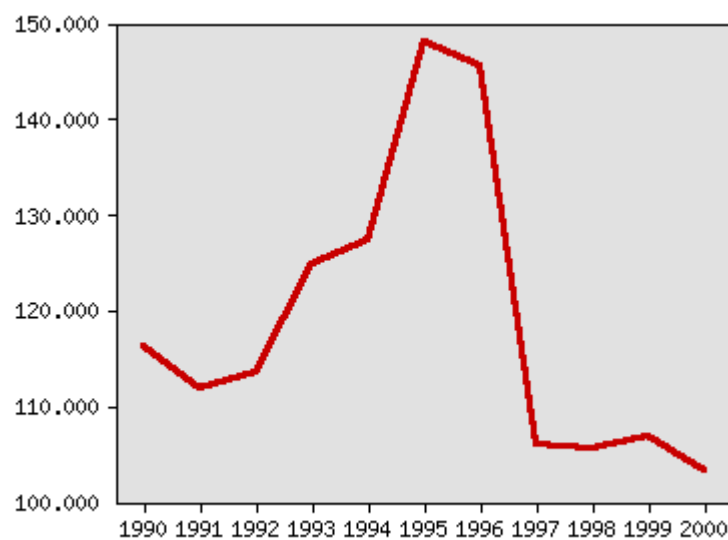
Year	
1990	410.6
1991	438.6
1992	405.9
1993	441.8
1994	438.8
1995	437.7
1996	421.5
1997	397.1
1998	404.5
1999	379.2
2000	333.0



Data source: Minnesota Department of Health

Years of potential life lost before age 65 to homicide, per 100,000 people

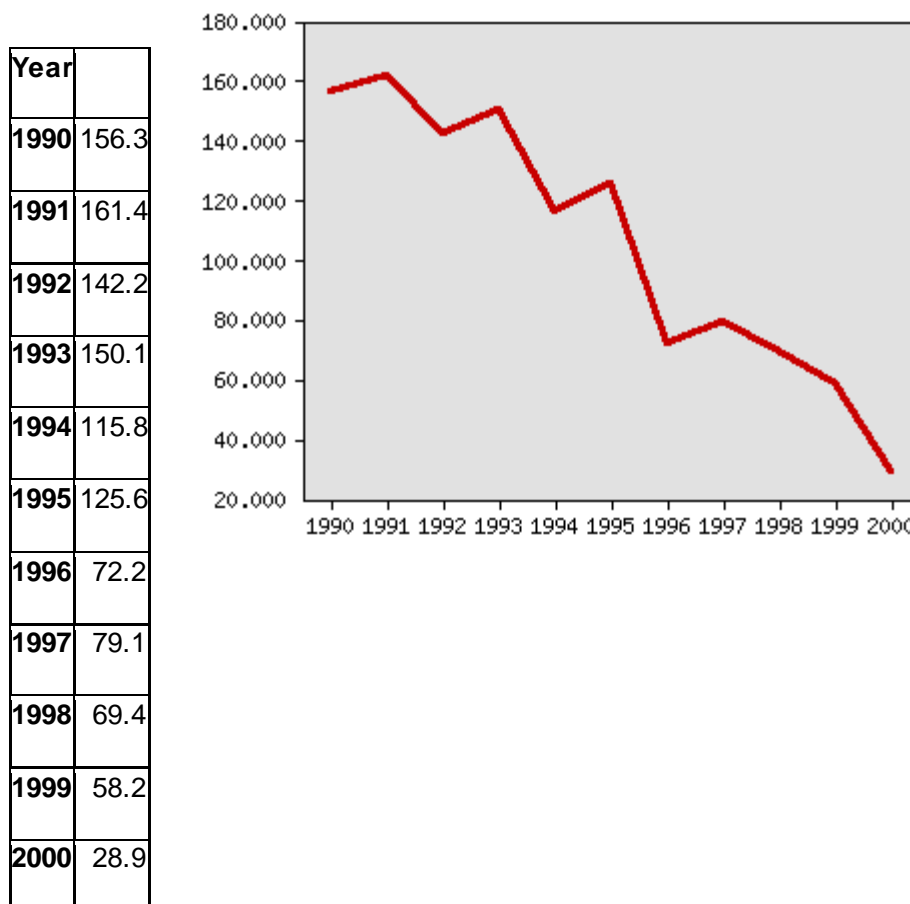
Year	
1990	116.2
1991	111.9
1992	113.5
1993	124.7
1994	127.4
1995	148.1



1996	145.6
1997	106.0
1998	105.5
1999	106.9
2000	103.2

Data source: Minnesota Department of Health

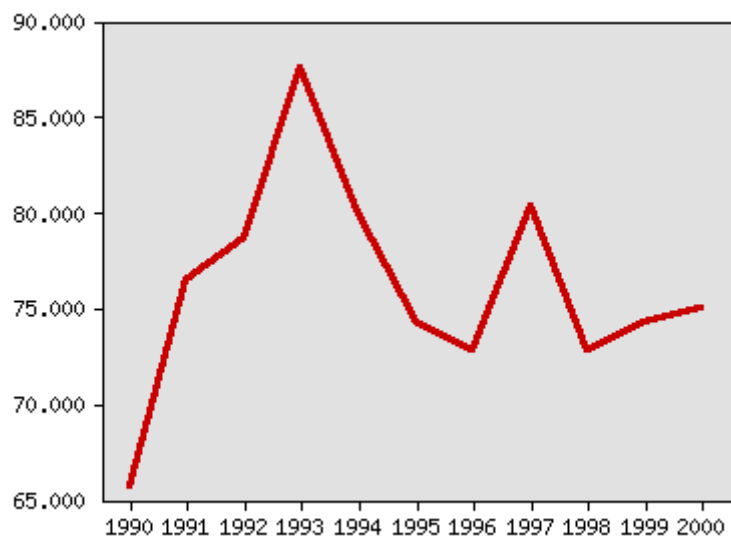
Years of potential life lost before age 65 to SIDS, per 100,000 people



Data source: Minnesota Department of Health

Years of potential life lost before age 65 to stroke, per 100,000 people

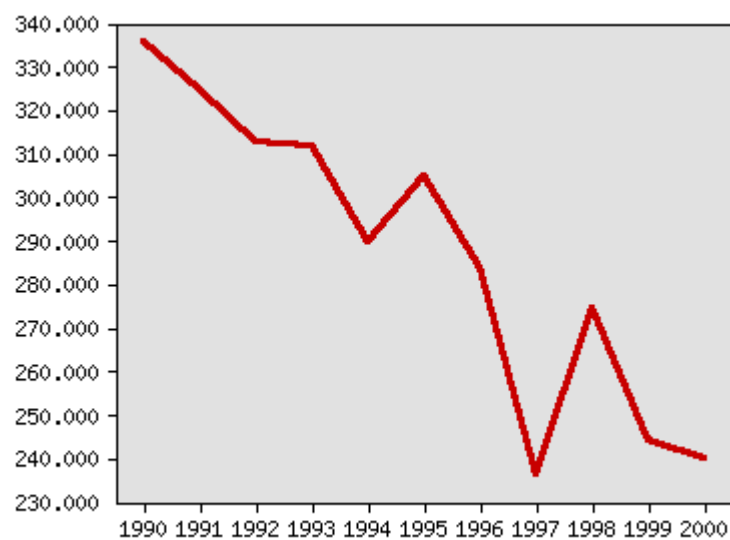
Year	
1990	65.7
1991	76.5
1992	78.6
1993	87.5
1994	79.9
1995	74.3
1996	72.8
1997	80.3
1998	72.8
1999	74.3
2000	75.0



Data source: Minnesota Department of Health

Years of potential life lost before age 65 to suicide, per 100,000 people

Year	
1990	335.7
1991	324.5
1992	312.7
1993	311.5
1994	289.4
1995	305.0

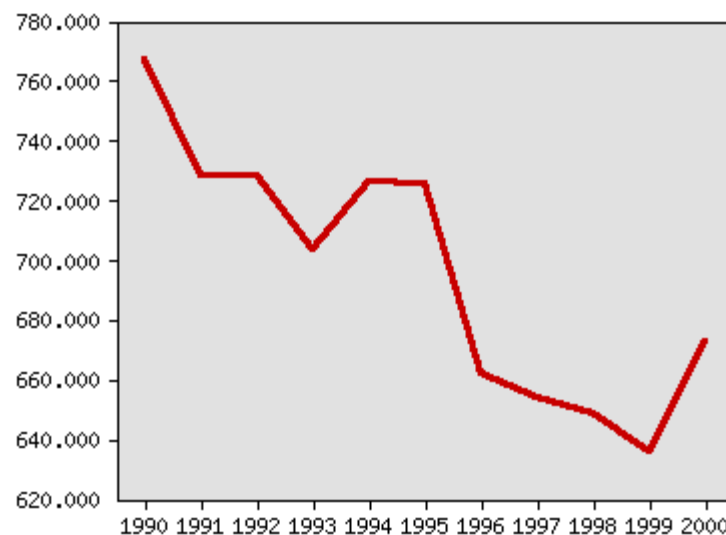


1996	283.4
1997	236.0
1998	274.3
1999	243.9
2000	239.8

Data source: Minnesota Department of Health

Years of potential life lost before age 65 to unintentional injury, per 100,000 people

Year	
1990	767.1
1991	728.1
1992	728.1
1993	703.4
1994	725.8
1995	725.7
1996	662.0
1997	653.7
1998	648.6
1999	636.0
2000	672.8



Data source: Minnesota Department of Health

About this indicator: This indicator has improved steadily and substantially since 1990, from 3,495 years per 100,000 people in 1990 to 2,829 years in 2000.

Unintentional injury and cancer are the the major causes of premature death followed by heart disease, suicide and homicide. The rates of premature death from AIDS/HIV and Sudden Infant Death Syndrome have decreased significantly during the decade, while the rates of premature death from diabetes have increased.

Minnesota has made significant progress in reducing deaths from unintentional injury, which includes motor vehicle crashes, falls, poisoning, suffocation, drowning and fire, although unintentional injury remains the leading cause of premature death.

For comparison: The National Center for Health Statistics reports premature death as any death before 75 years, compared to 65 years used in the Minnesota data. It is therefore no longer possible to make a direct comparison.

Things to think about: Research has shown that living conditions are an important factor in premature death. For example, studies have indicated that Whites living in low-income neighborhoods are 70 to 90 percent more likely to develop heart disease than Whites living in high-income neighborhoods. Blacks/African Americans living in low-income areas are 30 to 40 percent more likely to develop heart disease than those in high-income areas.

Experts indicate that a number of factors contribute to these neighborhood disparities. The U.S. Centers for Disease Control & Prevention has found the lack of decent, affordable housing to be strongly associated with health status. The health choices of individuals, including smoking, diet, and exercise, are also shaped by the norms of the communities in which they live. In 2001, the Minnesota Legislature allocated \$13.9 million for a statewide health disparities initiative.

Technical notes: Years of potential life lost are calculated by determining the number of years between death and age 65. The rate is calculated by dividing the years of potential life lost by the total population age 65 and younger, then multiplying by 100,000. The list of top causes of premature death excludes deaths related to perinatal conditions and birth defects.

Sources:

- Minnesota Department of Health, Center for Health Statistics www.health.state.mn.us

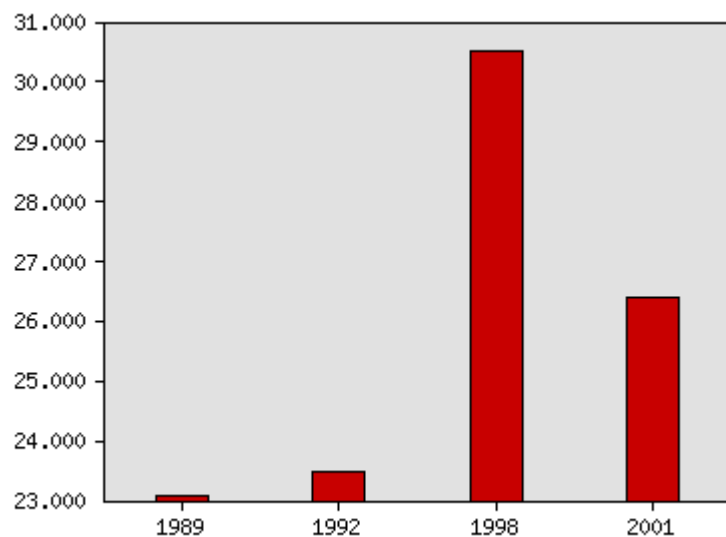
INDICATOR 19 : SMOKING AND TOBACCO USE

Goal: *Minnesotans will be healthy.* This goal encompasses both physical and mental health throughout life. It is also aimed at reducing disparities in health status among racial and ethnic minorities. Indicators for the goal deal with both health status and health care.

Rationale: Smoking and tobacco use have been shown to cause or worsen many diseases.

Percentage of 12th-graders who use tobacco daily

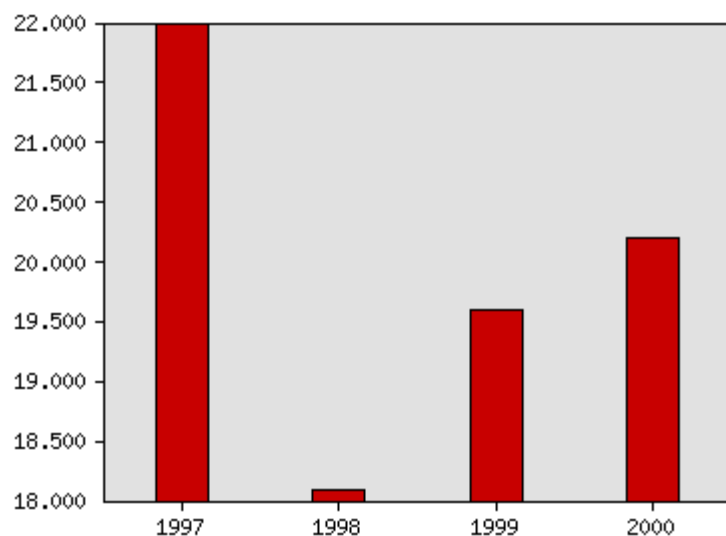
Year	
1989	23.1%
1992	23.5%
1998	30.5%
2001	26.4%



Data source: Minnesota Department of Children, Families & Learning

Percentage of adults who smoke

Year	
1997	22%
1998	18.1%
1999	19.6%
2000	20.2%



Data source: U.S. Centers for Disease Control and Prevention

About this indicator: The percentage of 12th-graders who use tobacco daily rose between 1992 and 1998, but fell again in 2001. The percentage of adults who smoke has remained steadier throughout the decade, falling between 1997 and 1998 but rising again in 1999.

Smoking-related diseases, such as cancer and heart disease, are the leading cause of preventable death in Minnesota and the nation. Studies show that most smokers begin by age 18, so reducing tobacco use among teens is seen as an important factor in reducing adult smoking.

The Minnesota Department of Health goal is to reduce adult smoking to 15 percent and daily smoking among 12th-graders to 15 percent by 2004.

For comparison: National surveys suggest that Minnesota has higher youth smoking rates, but lower adult smoking rates, than the nation as a whole. The University of Michigan Survey Research Center found that in 2000, 21 percent of U.S. 12th-graders smoked daily, compared to the Minnesota survey which found that 26 percent of Minnesota 12th-graders used tobacco daily in 2001.

Statistics from the U.S. Centers for Disease Control and Prevention indicate that smoking among U.S. adults has declined from 24.7 percent in 1997 to 23.0 percent in 2000. This is higher than the figure given for Minnesotans by the state Department of Health, which shows a decline from 22 percent to 19.6 percent in the same period.

Things to think about: The University of Michigan survey indicates that nationally, 41 percent of American Indian 12th-grade students said they smoked daily in 2000, the highest proportion of any ethnic group. Smoking among ninth-graders is also a concern for students of all races. Nationally, 32 percent of ninth-grade American Indians reported smoking daily, compared to 28 percent of Hispanic students, 17 percent of both Black/African-American and White youth and 14 percent of Asian/Pacific Islander students.

Nationally, adult smoking is more prevalent among men than women. There are more smokers among non-Hispanic Whites (24 percent) and Blacks/African Americans (23 percent) than among Hispanics (17 percent).

Technical notes: The Minnesota Student Survey of 12th-graders is conducted every three years. The data is self-reported and there are differences in the way school districts administer the survey. Fifty to 55 percent of Minnesota 12th-graders, approximately 34,000 students, participate in the survey.

Sources:

- Minnesota Department of Children, Families & Learning, Minnesota Student Survey, <http://cfl.state.mn.us>
- Minnesota Department of Health, *Healthy Minnesotans: Minnesota Health Improvement Goals for 2004*, www.health.state.mn.us
- University of Michigan Survey Research Center, Monitoring the Future, <http://monitoringthefuture.org>
- U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, Adult Core Component, www.cdc.gov

INDICATOR 2 0 : SUICIDE

Goal: *Minnesotans will be healthy.* This goal encompasses both physical and mental health throughout life. It is also aimed at reducing disparities in health status among racial and ethnic minorities. Indicators for the goal deal with both health status and health care.

Rationale: Suicide is an important public health indicator because it is a leading cause of premature death in Minnesota, and because it demonstrates the seriousness of mental health problems, including depression.

About this indicator: The suicide rate per 100,000 people declined from 12.3 in 1990 to 8.9 in 2000. Suicide is the second-leading cause of death in Minnesota for people between ages 10 and 34, after accidental injury. It is the eighth-leading cause of death for all ages. Three times as many people in Minnesota die from suicide as from homicide.

Males account for approximately 80 percent of all suicide deaths in the state. The suicide rate for American Indians is consistently higher than for any other ethnic or racial group. Minnesotans 65 and older have the highest suicide rate of all age groups. The three leading methods of suicide in Minnesota are firearms, suffocation and poisoning.

The Minnesota Department of Health goal is to reduce suicide by 20 percent for the general population and for all age, gender and race populations by 2004. Apart from saving lives, the aim is to reduce non-fatal suicide attempts and improve the social and emotional well-being of families and communities.

For comparison: Suicide rates are also falling nationwide. In 1998, the national rate was 10.6 per 100,000 population, compared to Minnesota's rate of 9.8.

Things to think about: In 1999, the Minnesota Department of Health prepared a plan to coordinate statewide efforts for suicide prevention. One emphasis of the plan is on public awareness and acceptance of mental health concerns.

Nationally, depression affects more than 19 million Americans each year, but it is estimated that only one in three people seek treatment. Each year, tens of thousands of people attempt suicide; 30,000 die.

Sources:

- Minnesota Department of Health, *Healthy Minnesotans, Minnesota Public Health Improvement Goals for 2004*, www.health.state.mn.us.
 - U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Report, www.cdc.gov/nchs
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